

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2011	
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715			
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F0000	<p>This visit was for a Recertification, State Licensure, and State Residential Licensure Survey.</p> <p>Survey dates: May 9, 10, 11, 12, 13, 16, 17, 2011</p> <p>Facility number: 002280 Provider number: 155723 Aim number: N/A</p> <p>Survey Team: Diane Hancock, RN, TC Martha Saull, RN Amy Wininger, RN</p> <p>Census bed type: SNF: 52 Residential: 40 Total: 92</p> <p>Census payor type: Medicare: 31 Other: 61 Total: 92</p> <p>Sample: 13</p>			F0000	<p>The submission of this plan of correction does not indicate an admission by River Pointe Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of River Pointe Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (for Title 18/19 programs) To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011

FORM APPROVED

OMB NO. 0938-0391

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	Supplemental sample: 9 Residential Sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 5-22-11 Cathy Emswiller RN						

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review, the facility failed to ensure the physician was notified of high blood pressures, for 1 of 1 supplemental sample resident observed with high blood pressures during the medication pass, in the supplemental sample of 9. (Resident #62)</p>			F0157	<p>F 157</p> <p>Resident 62 has been seen by the physician and his blood pressures have been review. An order has been written for B/P parameters and guidelines to notify the physician. Completion Date 6-10-2011</p> <p>All other residents have the potential</p>		06/10/2011

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	<p>Finding includes:</p> <p>During the medication pass, on 5/12/11 at 9:05 a.m., RN #1 was observed to check Resident #62's blood pressure using an electronic blood pressure machine. The blood pressure was read at 168/115. The pulse was read at 92 beats per minute. RN #1 proceeded to administer medication to the resident, including medications for high blood pressure at that time.</p> <p>On 5/12/11 at 10:40 a.m., Resident #62's clinical record was reviewed. A blood pressure log indicated the following: 5/11/11 0500 [5:00 a.m.] BP [blood pressure] 182/108, Pulse 134 5/11/11 0900 [9:00 a.m.] BP 159/109, P 96 5/12/11 0915 [9:15 a.m.] BP 168/115, P 93</p> <p>There was no indication the blood pressures had been reported to the physician.</p> <p>The high blood pressures were reviewed with the Director of Health Services [DoHS] and Minimum Data Set nurse, on 5/12/11 at 10:53 a.m. The DoHS indicated the resident's physician had a Nurse Practitioner, and she [the Nurse</p>				<p>to be affected by the deficient practice and through alterations in processes and in servicing will ensure physician notification. Completion Date 6-10-2011</p> <p>All nurses have been in serviced concerning the campus procedure for physician notification guidelines. Systemic change is the medical director has established parameters for high blood pressure physician notification. Completion Date 6-10-2011</p> <p>DHS/designee will review at random 3 resident's blood pressure documentation to ensure physician notification was complete as applicable. 5x a week for a month then 3x week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 6-10-2011</p>		

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	<p>Practitioner] was in the building and would evaluate the resident. "We'll get this all corrected."</p> <p>During interview at 11:22 a.m. on 5/12/11, the DoHS indicated the RN had reported she checked the blood pressure early the first morning, gave the blood pressure medications and rechecked the blood pressure at 9:00 a.m. The RN reported the 9:00 a.m. blood pressure was taken after therapy, so she associated the increased blood pressure with the activity. When the blood pressure was taken on 5/12/11 at 9:15 a.m., she indicated it was after therapy as well; she did not notify the physician.</p> <p>3.1-5(a)(2)</p>						

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F0280 SS=E	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure residents were able to participate in care planning, in that 4 of 7 residents who would have had quarterly care plan conferences did not have quarterly care plan conferences, in a sample of 14. (Residents #1, #35, #63, #49)</p> <p>Findings include:</p> <p>1. During initial tour, on 05/09/11 at 9:50 A.M., Resident #63 was identified by the DoHS [Director of Health Services] as interviewable.</p> <p>The clinical record of resident #63 was reviewed on 05/11/11 at 4:30 P.M.</p>			F0280	<p>F 280 Resident # 1, 35, 63, and 49 suffered no ill effects from the deficient practice. Care plan conferences have been held for the above residents. Completion Date 6-10-2011</p> <p>All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure residents are able to participate in care planning and the campus will conduct quarterly care plan conferences. Completion Date 6-10-2011</p> <p>The interdisciplinary team members have been in serviced on the procedure for quarterly care plan conferences. Systemic change is a</p>		06/10/2011

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	<p>During the group interview, on 05/11/11 at 11:00 A.M., Resident #63 was observed sitting in her scooter and was queried if she had the opportunity to participate in the care plan process and she indicated that she was not aware that the facility held care plan meetings.</p> <p>The most recent MDS [Minimum Data Set Assessment], dated 02/25/11, indicated the resident had no cognitive impairment.</p> <p>The clinical record indicated Resident #63 was admitted on 08/26/10.</p> <p>The Care Plan lacked any documentation that a care plan meeting had been held.</p> <p>A Social Service Progress note, dated 08/26/10, indicated, "SS [Social Service] welcomed resident back from the hospital this day and visited with her. Res. [Resident] stated she was glad to be back and was hopeful to return to AL [Assisted Living] unit once she was stronger..."</p> <p>A Service Plan, dated 05/16/10, was provided by the SSD [Social Service Designee], on 05/12/11 at 11:50 A.M., and was identified by the SSD as "from when she [Resident #63] was on Assisted Living." The Service Plan was signed by</p>				<p>tracking system has been put in place to assure care conferences are completed timely. Completion Date 6-10-2011</p> <p>ED/designee is to audit three random residents to assure care conferences are completed quarterly 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 6-10-2011</p>		

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	<p>facility staff on 05/16/10 and signed by Resident #63's daughter on 06/26/10.</p> <p>In an interview with the SSD, on 05/12/11 at 10:40 A.M., she indicated Resident #63 was her own responsible party.</p> <p>In an interview with the SSD, on 05/12/11 at 11:50 A.M., she indicated the Service Plan was filled out on 05/16/10 and she had the family sign it on 06/26/10 and that no actual care conference has been held since."</p> <p>2. During initial tour, on 05/09/11 at 10:00 A.M., Resident #35 was identified by the DoHS [Director of Health Services] as not interviewable.</p> <p>The clinical record of Resident #35 was reviewed on 05/11/11 at 10:30 A.M.</p> <p>The most recent MDS assessment, dated 04/22/11, indicated the resident had moderate cognitive impairment.</p> <p>The clinical record indicated Resident #35 was admitted on 01/21/11.</p> <p>The Care Plan lacked any documentation that a care plan meeting had been held.</p> <p>A Social Service Progress Note, dated 01/21/11, indicated, "Resident transferred</p>						

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	<p>to Health Center [certified area] from [facility] assisted living [unit]."</p> <p>In an interview with the SSD, on 05/12/11 at 11:55 A.M., she indicated, "No care plan meeting was held."</p> <p>3. During initial tour, on 05/09/11 at 10:10 A.M., Resident #64 was identified by the DoHS as interviewable.</p> <p>The clinical record of Resident #64 was reviewed on 05/11/11 at 11:40 A.M.</p> <p>The most recent MDS assessment, dated 04/15/11, indicated the resident had no cognitive impairment.</p> <p>The clinical record indicated Resident# #64 was re-admitted to the facility on 11/09/10.</p> <p>The Care Plan lacked any documentation that a care plan meeting had been held.</p> <p>In an interview with Resident #64, on 05/11/11 at 12:10 P.M., he indicated he had never been invited to a care plan meeting.</p> <p>In an interview with the SSD, on 05/12/11 at 12:10 P.M., she indicated no care plan meeting has been held since Resident #64 "returned to the facility in November."</p>						

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	<p>4. During initial tour, on 05/09/11 at 9:35 A.M., Resident #49 was identified by the DoHS as not interviewable.</p> <p>The clinical record of Resident #49 was reviewed on 05/12/11 at 3:25 P.M.</p> <p>The most recent MDS assessment, dated 02/15/11, indicated the resident had severe cognitive impairment.</p> <p>The clinical record indicated Resident #49 was admitted to the facility on 01/17/06.</p> <p>The Care Plan lacked any documentation that a care plan conference had been held.</p> <p>In an interview with the SSD, on 05/12/11 at 11:25 A.M., she indicated, "There hasn't been a care conference held for [name of Resident #49] since I came here in July of 2010."</p> <p>In an interview with the SSD, on 05/12/11 at 8:30 A.M., she indicated the Social Services staff "were weak at that [holding care conferences], We meet with family at different times... We have to get on top of that... We have to keep up with the regs [regulations]."</p> <p>In an interview with the SSD, on 05/12/11 at 11:50 A.M., she indicated, "We have so</p>						

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	<p>many, if every discipline went to every care conference, I don't know how we would run the building... we haven't had a good system of tracking and some have fallen through the cracks... We are supposed to hold care plan meetings quarterly."</p> <p>The policy and procedure for Resident First Meeting Guidelines was provided by the SSD, on 05/12/11 at 11:50 A.M., and indicated, "Purpose: To facilitate communication regarding the resident's plan of care, medical condition, and care needs between the resident, family, responsible party and care givers.... Procedure:... 2. should be scheduled quarterly..."</p> <p>3.1-35(c)(1)</p>						
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.						

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	<p>Based on observation, interview, and record review, the facility failed to ensure the plan of care was followed, for 2 of 6 sampled residents with histories of falls, in the total sample of 13, and 1 of 1 supplemental sample resident observed during the medication pass, in the supplemental sample of 9, in that the care plans for fall prevention were not followed for 2 residents and the written orders for medications were not followed for 1. (Residents #35, #3, #62)</p> <p>Findings include:</p> <p>1. During initial tour, on 05/09/11 at 10:00 A.M., Resident #35 was identified by the DoHS [Director of Health Services] as not interviewable and having a history of falls. Resident #35 was observed at that time sitting in a wheelchair in the hallway across from the nursing station with a clip alarm.</p> <p>The clinical record of Resident #35 was reviewed on 05/11/11 at 10:30</p>			F0282	<p>F 280 Resident # 1, 35, 63, and 49 suffered no ill effects from the deficient practice. Care plan conferences have been held for the above residents. Completion Date 6-10-2011</p> <p>All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure residents are able to participate in care planning and the campus will conduct quarterly care plan conferences. Completion Date 6-10-2011</p> <p>The interdisciplinary team members have been in serviced on the procedure for quarterly care plan conferences. Systemic change is a tracking system has been put in place to assure care conferences are completed timely. Completion Date 6-10-2011</p> <p>ED/designee is to audit three random residents to assure care conferences are completed quarterly 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments Completion Date 6-10-2011</p>		06/10/2011

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	<p>A.M. and indicated Resident #35 had a history of falls and dementia.</p> <p>The most recent MDS [Minimum Data Set Assessment], dated 04/22/11, indicated Resident #35 had a moderate impairment of cognitive function.</p> <p>The CNA [Certified Nursing Assistant] Assignment Sheet, provided by the DoHS on 05/09/11 at 9:45 A.M. and last updated 05/02/11, indicated Resident #35 was a fall risk, required a clip alarm to the bed, and a pressure alarm to the bed and chair.</p> <p>A Care Plan for falls, dated 02/10/11, indicated Resident #35 had a history of fall and was at risk for falls. The Fall Care Plan included, but was not limited to, interventions of "2/22/11 Clip alarm to bed at all times...3/5/11 Pressure alarm to bed and chair."</p> <p>The Nurse's notes, dated 04/09/11 at 1800 [6:00 P.M.], indicated,</p>						

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	<p>"Resident found lying on floor in bathroom with shirt off. Assisted to w/c [wheelchair] ...resident states he removed his clip alarm then took his shirt off, attempted to get in the shower and lost balance et [and] fell...Pressure alarm placed to w/c [wheelchair]. Resident instructed on fall prevention compliance with alarms."</p> <p>A Fall Circumstance, Assessment, and Intervention form, dated 04/09/11, indicated Resident #35 had fallen after removing his clip alarm.</p> <p>In an interview with the DoHS, on 05/11/11 at 12:00 P.M., she indicated that clip alarms and pressure alarms were both ordered for Resident #35. She further indicated that Resident #35 was known to remove the clip alarm and the pressure alarm would activate if he attempted to get out of the chair. The DoHS further indicated that staff had not put a pressure alarm in Resident #35's chair prior to the fall</p>						

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	<p>on 04/09/11, so when he removed the clip alarm the pressure alarm did not alert staff. The DoHS further indicated that the pressure alarm was not placed in the wheelchair because the intervention failed to be taken from the care plan and placed on the CNA [Certified Nursing Assistant] assignment sheet. The DoHS indicated, "The interventions would have been appropriate if they had been in place."</p> <p>2. During initial tour, on 05/09/11 at 10:05 A.M., Resident #3 was identified by the DoHS as not interviewable and having a history of falls.</p> <p>The clinical record was reviewed on 05/10/11 at 11:00 A.M.</p> <p>The Admission MDS [Minimum Data Assessment] dated 05/03/11 indicated Resident #3 had moderate cognitive impairment.</p> <p>The May 2011 Physician's Recap</p>						

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	<p>included, but was not limited to, a diagnosis of Alzheimer's Dementia [disease affecting memory]. The Physician's Recap further indicated, "[name of sitter service] to provide sitting services from 6 P.M. to 6 A.M. (sundowning increase)"</p> <p>A Care Plan for falls, dated 04/28/11, indicated Resident #3 was a risk for falls and included, but was not limited to, interventions...5/5/11 ...in direct line supervision if up in wheelchair and sitter not with him....5/8/11 every 15 minute checks til [sic] 6:00 A.M. then continue direct line supervision when up in wheelchair."</p> <p>The CNA [Certified Nursing Assistant] Assignment Sheet, provided by the DoHS on 05/09/11 at 9:45 A.M. and last updated 05/02/11, indicated Resident #3 was a fall risk, and required a pressure alarm to the bed and chair.</p> <p>The Nurse's Notes, dated 05/07/11</p>						

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	<p>at 1900 [7:00 P.M.], indicated, "Alarms heard, staff entered room immediately et observed Resident attempting to step over pressure alarm mat and turn off the alarm. Resident non-compliant with using call light, gets up without notice..."</p> <p>The Nurse's Notes, dated 05/07/11 at 2000 [8:00 P.M.], indicated, "Staff sees resident walking down hallway toward unit doors, no alarms sounding-shut off by resident. Senior Helper sitter not here tonight, unable to get another senior helper staff in...Contacted daughter...to update her on situation. States she cannot come in tonight. Monitoring."</p> <p>The Nurse's Notes, dated 05/08/11 at 0100 [1:00 A.M.], indicated, "Res. [resident] alarm sounding. Upon entering room res noted to be standing beside bed turning alarm off. 1:1 with res on importance of asking for assist. Expressed understanding but was again turning alarm off before staff could</p>						

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	<p>get in the room. The next entry was dated 05/08/11 at 0300 [3:00 A.M.] and indicated, "Res alarm sounding-is now sitting in floor on fall mat beside bed. Unable to state if he fell or sat on floor..."</p> <p>The Fall Circumstance Investigation, dated 05/05/11, indicated, "Res. will be supervised direct line-up in w/c [wheelchair]."</p> <p>The Fall Circumstance Investigation, dated 05/08/11, indicated Resident #3 was experiencing agitation/restlessness at the time of the fall and "continue with direct line supervision if not with sitter or in bed."</p> <p>In an interview with the DoHS, on 05/11/11 at 2:30 P.M., she indicated, Resident #3 had a fall on 05/05/11 related to the resident was "taken to his room after lunch and the staff left him unattended and he slid out of the wheelchair." The DoHS further indicated, Resident #3 had a fall on 05/07/11 related to,</p>						

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	<p>"The sitter from the agency called in and there was no replacement...I wish it had been done different...they know he has sundowner's...probably should have started 15 minute checks...there is no documentation that we were monitoring him...they should have called me so we could supervise him...If the sitter agency does not show up we have to provide supervision."</p> <p>A Nursing memo provided by the DoHS on 05/11/11 at 4:00 P.M. indicated, "DHS [Director of Health Services] should be notified of the following situations/incidents...Staffing issues that are of an urgent nature..."</p> <p>3. On 5/12/11 at 9:05 a.m., RN #1 was observed administering medications to Resident #62. She administered 7 [seven] oral medications in pill form. The resident's clinical record was reviewed, on 5/12/11 at 9:33 a.m., regarding medication orders. The resident had been admitted on 5/10/11. Admission medication orders, dated 5/10/11, included, but were not limited to, the following: Gliburide</p>						

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F0323 SS=E	<p>1.25 milligrams [mg] [medication for diabetes] three times daily before meals. The medication Gliburide was not provided. Review of the Medication Administration Record [MAR], on 5/12/11 at 9:33 a.m., indicated the Gliburide had not been included on the record, therefore not given.</p> <p>The omission of the glyburide for 2 days was reviewed with the Director of Health Services, on 5/12/11 at 10:53 a.m. She indicated the order had not been transcribed from the admission orders at the time of admission; the omission had been corrected.</p> <p>3.1-35(g)(2)</p>						
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure 2 of 6 residents with a history of falls, in the sample of 14, were provided with adequate supervision to</p>		F0323	<p>F 323</p> <p>Resident 35 and Resident 3 plan of care related to risk for falls has been reviewed and updated as necessary and staff has been in serviced on this plan of care.</p> <p>The pilot light on the stove has been</p>		06/10/2011	

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	<p>prevent accidents, in that Resident #35 was not provided a pressure alarm and experienced a fall and Resident #3 was not provided supervision and experienced a fall.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure safety procedures were observed in the lighting of a gas oven with an intermittently malfunctioning pilot light, for 2 of 3 kitchen observations. This had the potential to affect 52 residents residing in the facility.</p> <p>Findings include:</p> <p>A1. During initial tour, on 05/09/11 at 10:00 A.M., Resident #35 was identified by the DoHS [Director of Health Services] as not interviewable and having a history of falls. Resident #35 was observed at that time sitting in a wheelchair in the hallway across from the nursing station with a clip alarm.</p> <p>The clinical record of Resident #35 was reviewed, on 05/11/11 at 10:30 A.M., and indicated Resident #35</p>				<p>reviewed by GCS. Completion Date 6-10-2011</p> <p>All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Completion Date 6-10-2011</p> <p>Nursing staff have been in serviced concerning Fall/Safety Management. Systemic change is the C.N.A. Assignment sheet that communicates to the C.N.A. fall and safety interventions will be updated immediately after a new intervention is put in place. Dietary Staff have been in serviced on lighting the pilot light per manufactures guidelines. Systemic change is all dietary employees will complete competency on lighting the pilot light now and annually thereafter. Completion Date 6-10-2011</p> <p>DHS /designee will monitor 3 random resident at risk for falls to</p>		

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	<p>had a history of falls and dementia.</p> <p>The most recent MDS [Minimum Data Set Assessment], dated 04/22/11, indicated Resident #35 had a moderate impairment of cognitive function.</p> <p>The CNA [Certified Nursing Assistant] Assignment Sheet, provided by the DoHS on 05/09/11 at 9:45 A.M. and last updated 05/02/11, indicated Resident #35 was a fall risk, required a clip alarm to the bed, and a pressure alarm to the bed and chair.</p> <p>A Care Plan for falls, dated 02/10/11, indicated Resident #35 had a history of a fall and was at risk for falls. The Fall Care Plan included, but was not limited to, interventions of "2/22/11 Clip alarm to bed at all times...3/5/11 Pressure alarm to bed and chair."</p> <p>An additional Care Plan for cognitive impairment, dated 02/10/11, indicated Resident #35</p>				<p>assure safety interventions in place as per plan of care and staff following plan of care to prevent an accident 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>ED/designee will quiz one random dietary employee on how to light the pilot light 5x a week for a month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p>		

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	<p>had decision making, memory, and recall problems. The care plan also indicated Resident #35 had problems understanding others r/t [related to] dementia. The interventions included, but were not limited to, "conduct regular safety checks."</p> <p>The Nurse's notes, dated 04/09/11 at 1800 [6:00 P.M.], indicated, "Resident found lying on floor in bathroom with shirt off. Assisted to w/c [wheelchair] ...resident states he removed his clip alarm then took his shirt off, attempted to get in the shower and lost balance et [and] fell...Pressure alarm placed to w/c [wheelchair]. Resident instructed on fall prevention compliance with alarms."</p> <p>A Fall Circumstance, Assessment, and Intervention form, dated 04/09/11, indicated Resident #35 had fallen after removing his clip alarm.</p> <p>In an interview with the DoHS, on</p>						

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	<p>05/11/11 at 12:00 P.M., she indicated that clip alarms and pressure alarms were both ordered for Resident #35. She further indicated that Resident #35 was known to remove the clip alarm and the pressure alarm would activate if he attempted to get out of the chair. The DoHS further indicated that staff had not put a pressure alarm in Resident #35's chair prior to the fall on 04/09/11, so when he removed the clip alarm, the pressure alarm did not alert staff. The DoHS further indicated that the pressure alarm was not placed in the wheelchair because the intervention failed to be taken from the care plan and placed on the CNA [Certified Nursing Assistant] assignment sheet. The DoHS indicated, "The interventions would have been appropriate if they had been in place."</p> <p>A2. During initial tour, on 05/09/11 at 10:05 A.M., Resident #3 was identified by the DoHS as not interviewable and having a</p>						

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	<p>history of falls.</p> <p>The clinical record was reviewed on 05/10/11 at 11:00 A.M.</p> <p>The Admission MDS [Minimum Data Set Assessment], dated 05/03/11, indicated Resident #3 had moderate cognitive impairment.</p> <p>The May 2011 Physician's Recap included, but was not limited to, a diagnosis of Alzheimer's Dementia [disease affecting memory]. The Physician's Recap further indicated, "[name of sitter service] to provide sitting services from 6 P.M. to 6 A.M. (sundowning increase)"</p> <p>A Care Plan for falls, dated 04/28/11, indicated Resident #3 was a risk for falls and included, but was not limited to, interventions...5/5/11 ...in direct line supervision if up in wheelchair and sitter not with him....5/8/11 every 15 minute checks til [sic] 6:00 A.M. then continue direct line supervision when up in</p>						

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	<p>wheelchair."</p> <p>The CNA [Certified Nursing Assistant] Assignment Sheet, provided by the DoHS on 05/09/11 at 9:45 A.M. and last updated 05/02/11, indicated Resident #3 was a fall risk, and required a pressure alarm to the bed and chair.</p> <p>The Nurse's Notes, dated 05/07/11 at 1900 [7:00 P.M.], indicated, "Alarms heard, staff entered room immediately et observed Resident attempting to step over pressure alarm mat and turn off the alarm. Resident non-compliant with using call light, gets up without notice..."</p> <p>The Nurse's Notes, dated 05/07/11 at 2000 [8:00 P.M.], indicated, "Staff sees resident walking down hallway toward unit doors, no alarms sounding-shut off by resident. Senior Helper sitter not here tonight, unable to get another senior helper staff in...Contacted daughter...to update her on situation. States she cannot come</p>						

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	<p>in tonight. Monitoring."</p> <p>The Nurse's Notes, dated 05/08/11 at 0100 [1:00 A.M.], indicated, "Res. [resident] alarm sounding. Upon entering room res noted to be standing beside bed turning alarm off. 1:1 with res on importance of asking for assist. Expressed understanding but was again turning alarm off before staff could get in the room. The next entry was dated 05/08/11 at 0300 [3:00 A.M.] and indicated, "Res alarm sounding-is now sitting in floor on fall mat beside bed. Unable to state if he fell or sat on floor..."</p> <p>The Fall Circumstance Investigation, dated 05/05/11, indicated, "Res. will be supervised direct line-up in w/c [wheelchair]."</p> <p>The Fall Circumstance Investigation, dated 05/08/11, indicated Resident #3 was experiencing agitation/restlessness at the time of the fall and "continue with direct line supervision if not</p>						

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	<p>with sitter or in bed."</p> <p>In an interview with the DoHS, on 05/11/11 at 2:30 P.M., she indicated, Resident #3 had a fall on 05/05/11 related to the resident was "taken to his room after lunch and the staff left him unattended and he slid out of the wheelchair." The DoHS further indicated, Resident #3 had a fall on 05/07/11 related to, "The sitter from the agency called in and there was no replacement...I wish it had been done different...they know he has sundowner's...probably should have started 15 minute checks...there is no documentation that we were monitoring him...they should have called me so we could supervise him...If the sitter agency does not show up we have to provide supervision."</p> <p>A Nursing memo provided by the DoHS on 05/11/11 at 4:00 P.M. indicated, "DHS [Director of Health Services] should be notified of the following</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011

FORM APPROVED

OMB NO. 0938-0391

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	<p>situations/incidents...Staffing issues that are of an urgent nature..."</p> <p>B. On 5/9/11 at 1:10 P.M., Cook #2 was observed standing by the oven. He took a large piece of parchment type paper, rolled it in a long cone shaped manner and lit it in the flame from the gas stove top. He then kneeled down on the floor, opened the thin panel (which extended the entire front width of the oven), located below the oven door, pushed in a button while holding it and then stuck the lit paper into the area under the stove. He then carried the lit paper to the back of the kitchen in an area behind a wall.</p> <p>On 5/11/11 at 11:40 A.M., Cook #2 was observed to again roll up parchment type paper, kneel down, open the small panel below the oven door, push the button below the oven and then, with the lit paper, tried to light the pilot light.</p> <p>On 5/11/11 at 12 P.M., Cook #3 was observed to roll up parchment type paper, kneel down and holding a button in the panel below the oven door, she was counting. She then took the lit parchment paper and lit the pilot light below the oven door.</p> <p>On 5/11/11 at 3:35 P.M., Cook #2 was interviewed. He indicated that the cooks</p>						

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	<p>don't have to light the pilot light to the oven every day. He indicated the pilot light has not been working on and off for about 2 months. Cook #2 indicated sometimes the pilot light goes out. He indicated there are different ways to light the oven pilot light. He indicated you can lift the oven racks up and light the pilot from inside the oven down and /or open the front panel located below the oven door. Cook #2 indicated Cook #1 had showed him how to use the rolled parchment paper to reach the pilot light. He indicated Cook #1 told him to hold the button to the pilot light for 30 seconds to prime the line with gas. Cook #2 indicated they had a lighter (similar to one used on a grill) but it wasn't long enough to reach the pilot light. He indicated after using the lit parchment paper, they take the paper to the sink and put it under running water before disposing of it.</p> <p>On 5/11/11 at 4:38 P.M. a copy of the Maintenance Request, dated 4/22/11, was provided by the Administrator. The location identified as the kitchen, and the problem: "thermocouple needs cleaned. Pilot light not lighting." Remarks: "cleaned thermocouple pilot light working OK now."</p> <p>On 5/11/11 at 4:55 P.M., the Regional Representative [RR] provided a copy of</p>						

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	<p>the directions regarding "operation" of the oven. This form was undated. This form included, but was not limited to, the following information: "...To light the pilot of an oven, do the following: Turn oven thermostat to "off" position...open door, remove oven bottom and fire plate to expose pilot and burner, open kick panel and depress red button on oven safety valve, light constant pilot..."</p> <p>On 5/11/11 at 4:55 P.M., the RR was interviewed. He indicated the pilot light to the oven was running out. He indicated a call was placed to the (name of company) last week. The RR indicated the problem was a combination of when the door to kitchen is open it creates a vacuum and the pilot light goes out. He indicated the oven needs new jets and it was an ongoing problem. He indicated he was first made aware of this problem last week. He indicated the maintenance man adjusted the light.</p> <p>On 5/11/11 at 5 P.M., the RR was interviewed. He indicated that using a rolled up piece of parchment paper "isn't the best way to fly" regarding the way the oven was being lit.</p> <p>On 5/12/11 at 3 P.M., the Administrator provided a work order receipt received from "[name of lab documented]." This</p>						

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F0333 SS=G	<p>order was dated 5/12/11. The form identified the following problem description: "Pilot won't stay lit" for the "range." The service performed included the following: "5/12...talked to (maintenance man name) problem is intermittent. checks at this time show all is good. (maintenance man name) to let us know if anything else develops."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure it was free of significant medication errors, for 1 of 1 supplemental sample resident reviewed for medications, in the supplemental sample of 9, in that the new admission was ordered to receive Lasix [diuretic] once a day and received it three times a</p>			F0333	<p>F 333</p> <p>Resident # 62's medication orders have been reviewed by the primary physician. Completion Date 6-10-2011</p> <p>All residents have the potential to</p>		06/10/2011

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	<p>day, resulting in a low potassium level, and then received less than the ordered potassium for two days. (Resident #62)</p> <p>Finding includes:</p> <p>Resident #62's clinical record was reviewed on 5/16/11 at 10:50 a.m. The resident was admitted to the facility on 5/10/11 with diagnoses including, but not limited to, congestive heart failure [CHF], severe pulmonary hypertension [PHTN], coronary artery disease [CAD] syncope, acute renal insufficiency [ARI], ischemic cardiomyopathy, chronic obstructive pulmonary disease, and diabetes mellitus. Medication orders from the hospital included, but were not limited to, "Lasix, 40 mg [diuretic] po [by mouth] 1 [one] tab po daily."</p> <p>Review of the Medication Administration Record [MAR], on 5/16/11 at 10:55 a.m., indicated the order for Lasix had been transcribed as "Lasix 40 mg p.o. T.I.D. [three times a day] before meals." The medication had been documented as given three times a day on 5/11, 5/12, 5/13, 5/14, 5/15, and once thus far on 5/16/11.</p> <p>Physician's orders had been obtained on 5/13/11, for KCL [potassium chloride] 40 meq [40 milliequivalents] two times a day orally. A lab report indicated the</p>				<p>be affected by the alleged deficient practice and through altercations in processes and in servicing the campus will ensure measures to prevent medication errors</p> <p>Completion Date 6-10-2011</p> <p>Nursing staff have been in serviced on medication orders regarding passing medications and transcription of medication orders/lab orders. Systemic change is physician orders transcribed to the medication administration sheet will be reviewed by two nurses. All nurses and QMAs will complete a medication pass competency now and annually thereafter.</p> <p>Completion Date 6-10-2011</p> <p>DHS/designee will review new admission orders in daily clinical meeting to assure orders where reviewed for accuracy 5x week x one month 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Nurse managers will perform random audits of 2 nurses passing medication for 2 random</p>		

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	<p>resident's potassium level was 2.8 on 5/13/11, with normal ranges being 3.5-5.4. A follow-up potassium level, on 5/16/11, was noted to be 2.6.</p> <p>The error in transcription was reviewed with the physician's Nurse Practitioner, on 5/16/11 at 10:55 a.m. She indicated the Lasix being given more frequently than ordered would account for the low potassium level, and indicated she was unaware of the error.</p> <p>The Director of Nursing indicated, on 5/16/11 at 11:00 a.m., she would need to review the orders and the MAR. At 11:30 a.m., she indicated it did appear there was an error, however, she pointed out the Nurse Practitioner had seen the resident on 5/12 and 5/13/11 and indicated to continue the same orders, including the Lasix 40 mg three times a day.</p> <p>According to the Lippincott Manual of Nursing Practice Handbook, third edition, hypokalemia [low potassium levels] can be caused by diuretic therapy. Signs and symptoms of hypokalemia included weakness, lethargy, anorexia, abdominal distention, decreased bowel sounds, and muscle tenderness. The manual indicated hypokalemia resulted more quickly with loop diuretic therapy, such as furosemide [Lasix].</p>				<p>residents 5x week x one month 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments Completion Date 6-10-2011</p>		

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	<p>The Director of Health Services was interviewed on 5/16/11 at 3:00 p.m. She indicated the procedure for reviewing new admission orders for accuracy was the following: a nurse transcribes the orders onto the facility order sheet and signs it, a second nurse reviews the orders for accuracy and signs it, a nurse manager is supposed to do a third check of the orders for accuracy. In this case, she indicated there were 4 new admissions that date. LPN #2 took the orders off of the admission orders, LPN #3 [a nurse manager] did the initial check for accuracy and signed off on them. RN #2 was supposed to review the orders for accuracy an additional time. The Director of Health Services indicated RN #2 noted that LPN #3 had reviewed them and LPN #3 was a nurse manager, so she did not follow through with her review, since a nurse manager had already reviewed them. She indicated they were in the process of looking at the process and where it broke down.</p> <p>The Medication Administration Record [MAR] was reviewed, regarding the potassium chloride, on 5/16/11 at 2:30 p.m. It indicated the potassium chloride 40 meq p.o. twice a day was started on 5/14 in the morning. the MAR indicated two doses were given on 5/14 and two</p>						

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	<p>doses on 5/15 and one dose on 5/16. Review of the medication provided from the pharmacy indicated it was delivered on 5/13/11. There were 30 tablets delivered of 20 meq each. The label indicated two tablets were to be given twice a day. There were 24 tablets left at the time of the review. RN #1 was present and indicated she had given two tablets that morning. Ten [10] tablets should have been missing for 5 doses of 40 meq each. RN #1 then checked the Emergency Drug Kit [EDK]. No doses of potassium had been signed out for Resident #62.</p> <p>This information was reviewed with the Director of Health Services [DoHS] on 5/16/11 at 3:00 p.m. She indicated the back up pharmacy could have provided some doses and she would check. At 3:45 p.m., she reported they could find no further evidence of additional medication being provided, so he must have gotten half the potassium dose over the weekend, i.e. 20 meq twice a day instead of 40 meq twice a day.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>						

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F0361 SS=F	<p>The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.</p> <p>If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.</p> <p>A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.</p> <p>Based on observation, interview and record review, the facility failed to ensure the kitchen had a qualified Food Service Manager (FSM) in attendance and/or upon the FSM's absence; the facility failed to provide a qualified designee to oversee the operations of the kitchen for 42 of the 50 days (from 3/9/11 to 5/17/11). This had the potential to affect 52 residents residing in the facility.</p> <p>Findings include:</p> <p>On initial tour of the kitchen, on 5/9/11 at 9:20 A.M., Cook #1 was interviewed. He indicated the FSM (food service manager) was not at work; she was sick. At 11 A.M., Cook #1 was again interviewed. He indicated that Cook #3 would be the staff person to direct inquires to, as "she's</p>			F0361	<p>F 361</p> <p>No residents suffered any ill effects from the deficient practice .</p> <p>All residents have the potential to be affected by the deficient practice and through the designation of a qualified food service director, sanitation and overall kitchen operation will meet such requirements set forth by the Indiana Department of Health.</p> <p>Completion Date 6-10-2011</p> <p>The new designated food service manager will be enrolled in the required courses to meet the Indiana State Department of Health requirement for qualified food service manager. The designee will also receive training and orientation by the Divisional Home Office</p>		06/10/2011

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	<p>the cook who has been here the longest."</p> <p>On 5/11/11 at 8:40 A.M., Cook #1 was observed in the kitchen. Cook #1 indicated sometimes they run out of eggs and buy them from the store. Cook #1 indicated the eggs purchased from the store were unpasteurized.</p> <p>On 5/11/11 at 9 A.M., Cook #3 was interviewed. She indicated the FSM was currently in the hospital and had been gone for 2 - 3 months. She indicated the Assistant FSM was currently on medical leave and she had been gone for 1 1/2 months.</p> <p>On 5/11/11 at 9:25 A.M., Dishwasher #1 was interviewed regarding the 3 compartment sink. He indicated the first sink contained soapy water for soaking items, the second sink was the rinse sink and the third sink is where staff filled their buckets with the sanitizing solution. The first sink was observed to have soapy water in it with various cooking pans in it, sticking up out of the water. The second sink was also filled with clear water as well as the third sink, also filled with clear liquid. Dishwasher #1 explained how the sanitizer was dispensed by a hose on the wall, connected to a bottle of sanitizer. Viewing the bottle of sanitizer was obstructed, as there were dish racks</p>				<p>Support Food Service Staff. Completion date 6-10-2011</p> <p>ED/Designee will monitor progression of course work once a week until the requirement has been met. Completion Date 6-10-2011</p>		

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	<p>stacked up in front of it. Upon request, Dishwasher #1 was asked to test the strength of the sanitizer level in the 3rd sink. He took the test strips, labeled Phydration, and took the orange strip of paper and stuck it in the 3 compartment sink. He indicated he was to hold the strip in the water for 10 seconds. When he removed the test strip, it was the same orange color as when he removed it from the dispenser. Dishwasher #1 indicated they "were low on sanitizer." When the dispensing tube was followed along the wall, behind the stacked dish racks, an empty metal holder was observed. He indicated someone had "gone to get more" sanitizing solution.</p> <p>On 5/11/11 at 11 A.M., the Dietician was interviewed. She indicated she only does the clinical reviews. She indicated she does nothing in the kitchen, no tray lines and no sanitation.</p> <p>On 5/11/11 at 3:08 P.M., the kitchen was toured with the Regional Representative [RR]. At that time, Cook #2 was asked by the RR to cover the pans of carrot salad which were observed in the walk in refrigerator on standing racks uncovered. Cook #2 indicated they didn't have any plastic wrap. The carrot salad was then covered with cookie sheet type pans.</p>						

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	<p>On 5/12/11 at 4:15 P.M., the Administrator provided copies of the FSM (food service manager) and the AFSM (assistant food service manager) forms indicating the times the staff were off work.</p> <p>On 5/16/11 at 10 A.M., a copy of the facility contract agreement for the Certified Dietitian with the facility was received from the administrator. This contract included, but was not limited to, the following: "...The facilities hereby retains (name of nutrition management company) to provide Nutrition Management Services...initial term...two year term beginning on August 1, 2009 thru July 2011...Consultant dietician services...includes the provision of clinical nutrition, food service monitoring and educational programs...Management:...Report preparation...Sanitation Review, Meal Service Observation..."</p> <p>On 5/16/11 at 11:20 A.M., the Administrator was interviewed. She indicated while both the FSM and the AFSM were not in the building, there were FSMs here from 2 other buildings. She also indicated the RR (regional representative) had been here during that time also. The Administrator indicated during the time both the FSM and AFSM</p>						

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	<p>were out of the building, she did the staffing but she got help with the food ordering from FSMs from other facilities. She indicated when both the dietary supervisory staff were gone, she would have been the contact person for dietary staff to contact with questions/concerns. She indicated that no one person was overseeing the day to day operations of the dietary department. The Administrator indicated she was fulfilling the open dietary supervisory roll to the best of her ability.</p> <p>On 5/16/11 at 1:33 P.M., the Administrator and RR were interviewed. The Administrator indicated the following: She took the cooks that she had with strengths and scheduled them in the absence of the FSM. She indicated she took over the ordering of the food. She indicated other FSMs were available from other facilities and "probably 15 days were covered with other people out of all the days" the FSM and AFSM were gone.</p> <p>On 5/16/11 at 2:10 P.M., the Administrator provided documentation in the form of calendars for the months of March, April and May 2011 indicating the dietary coverage. The information indicated the following: The Food Service Manager (FSM) was out of the</p>						

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	<p>building from 3/9/11 and returned on 3/28/11. The FSM was then gone from 4/4/11 and remained on leave to the current date. The assistant food service manager (AFSM) was on leave from 2/21/11 until 4/26/11. The AFSM then went on leave again on 5/9/11 and remained off to the current date.</p> <p>Regarding outside support from other buildings in the dietary department, the following coverage was documented on the calendars: For March: On 3/29/11, the RR (regional representative) was here; In April: FSMs were in the building for 8 hours on the following dates: 3/14, 4/5, 4/7, 4/11, 4/13, 4/14, 4/19, 4/21. The RR was also in the building on 4/7/11. The May calendar, indicated the following for FSM coverage: RR here 5/2, 5/4, 5/11, 5/12 and 5/16.</p> <p>On 5/17/11 at 9:20 A.M., the Administrator was interviewed. She indicated the Certified Dietitian was in the building 20 hours a week, reviewing resident records and making clinical recommendations. She indicated the company did not want the Certified Dietitian to be responsible for issues such as kitchen sanitation and meal preparation, but the company wanted the facility to be responsible for those issues themselves.</p>						

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F0363 SS=E	<p>3.1-20(c)</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure recipes were followed for food preparation for 1 of 1 meal preparation observed (5/11/11 noon meal), in that a recipe was not used and when the recipe was reviewed, it had not been followed. This had the potential to affect 52 residents.</p> <p>Findings include:</p> <p>On 5/11/11 at 11:30 A.M., Cook #1 was observed preparing the menued noon entree of beef stroganoff. Cook #1 indicated he had cooked 20 lbs (pounds) of meat and added onions and 3 bags of gravy to the pot of meat. He was observed at this time to scoop sour cream out of a container into the pot of cooked meat and gravy. Cook #1 did not measure the sour cream. At this time, Cook #1</p>			F0363	<p>F 363</p> <p>No residents suffered any ill effects from the deficient practice .</p> <p>All residents have the potential to be affected by the deficient practice and through the in-servicing and monitoring of the preparation of meals, recipes will be followed for each meal prepared. Completion Date 6-10-2011</p> <p>All cooks will be in-serviced on recipe books and the importance of following recipes for the nutritional balance of meals for each resident. Completion Date 6-10-2011</p> <p>FSM/Designee will monitor the preparation of meals to ensure recipes are being followed. Monitoring will take place 1 meal 5x per week for 1 month and then 1 meal 3x per week for 2 months with</p>		06/10/2011

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	<p>was interviewed. He indicated he added 4 lbs of sour cream, out of a 5 lb container. No recipe was observed out in view for reference. At 11:40 A.M., Cook #1 took a bottle of "kitchen Bouquet" and added several squirts to the beef stroganoff pot. Cook #1 did not measure the kitchen bouquet. Cook #1 indicated the beef stroganoff included the following ingredients: beef, onion, gravy, sour cream and the kitchen bouquet.</p> <p>On 5/12/11 at 11:30 A.M., a copy of the undated policy and procedure "Left over foods will be utilized in an appropriate and safe manner to aid in controlling waste," was received from the Regional Representative [RR]. The procedure included, but was not limited to, the following: "Recipes should be followed assuring appropriate amounts are prepared to prevent overproduction and waste..."</p> <p>On 5/12/11 at 11:30 A.M., the RR provided a copy of the recipe for the Beef Stroganoff which was prepared on 5/11/11. Ingredients included the following: "Beef tenderloin...unsalted butter, fresh sliced mushrooms, Spanish onions, dill weed, salt, black pepper,...cooking wine and lite sour cream."</p> <p>On 5/16/11 at 3 P.M., the RR (regional</p>				<p>results being forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions and recommendations.</p> <p>Completion Date 6-10-2011</p>		

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F0368 SS=E	<p>representative) was interviewed. He indicated the cook had prepared enough beef stroganoff, on 5/11/11 at the noon meal, for 100 servings. The recipe for beef stroganoff indicated, for 100 servings, 25 pounds of beef tenderloin should have been used.</p> <p>3.1-20(i)(4)</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on interview and record review, the facility failed to ensure residents were offered a bedtime snack, in that 7 of 7 alert and oriented residents confidentially interviewed during the group interview, and 2 of 3 sampled individual interviews,</p>			F0368	<p>F 368</p> <p>Resident # 54, 55, 56, 57, 58, 59, 60, 61, suffered no ill effects from the alleged deficient practice. Completion Date 6-10-2011</p> <p>All other residents have the potential</p>		06/10/2011

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	<p>in the sample of 13, indicated they were not offered bedtime snacks. (Residents #53, #54, #55, #56, #57, #58, #59, #60, #61)</p> <p>Findings include:</p> <p>In a confidential group interview, conducted on 05/10/11 at 11:00 A.M., Residents #53, #54, #55, #56, #57, #58, and #59 indicated the facility did not offer evening snacks.</p> <p>In a confidential interview with Resident #61, on 05/10/01 at 9:45 A.M., she indicated, "No snacks in the evening..."</p> <p>In a confidential interview with Resident #60, on 05/10/11 at 1:20 P.M., he indicated he did not receive an evening or bedtime snack.</p> <p>In an interview with CNA #1, on 05/11/11 at 3:30 P.M., she indicated there was a basket of snacks at the nursing station if the residents wanted something.</p> <p>A Policy for "Guidelines for Between Meal Snacks," provided by the DoHS on 05/11/11 at 4:00 P.M., indicated, "Purpose: To provide for nutrition between meals. Procedure:...7.) Ask the resident if he/she wishes to be served a snack..."</p>				<p>to be affected by the deficient practice and through alterations in processes and in servicing will ensure the campus offers snacks at bedtime daily.</p> <p>Completion Date 6-10-2011</p> <p>Dietary and Nursing staff have been in serviced related to offering snacks at bedtime. Systemic change is nursing will initial when dietary delivers the snacks</p> <p>Completion Date 6-10-2011</p> <p>DHS/designee will ask 3 random alert and oriented residents if they were offered a snack the evening prior 5x a week for a month then 3x week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.</p> <p>Completion Date 6-10-2011</p>		

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F0371 SS=F	<p>In an interview with the DoHS, on 05/11/11 at 4:00 P.M., she indicated the provided policy was also for evening snacks.</p> <p>3.1-21(e)</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure sanitation solution was at adequate levels; kitchen dishwasher temperatures were consistently maintained at adequate levels; foods were stored covered, dated and labeled and/or disposed of according to facility procedure; serve pasteurized eggs when not thoroughly cooked; monitor refrigerator/freezer temperatures; maintain the kitchen in a sanitary manner; and/or ensure all staff (including non-dietary staff) were wearing hair restraints when in the kitchen, for 3 of 3 food preparation/serving areas and/or dining areas. (Transitional Care Unit</p>			F0371	<p>F 371</p> <p>No residents suffered any ill effects from the deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice and through the in-servicing of staff and alterations of processes will ensure proper sanitation and food storage guidelines are being met.</p> <p>Completion Date 6-10-2011</p> <p>All dietary staff have been in-serviced on the proper way to check sanitizer levels in their cleaning buckets as well as the 3 compartment sink.</p>		06/10/2011

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	<p>Dining Room, Main Dining Room, Health Center Dining Room)</p> <p>This deficient practice had the potential to affect all 52 residents as this kitchen prepared food for all the healthcare residents.</p> <p>Findings include:</p> <p>1. Initial tour of the kitchen began on 5/9/11 at 9:20 A.M. Cook #1 was observed to take a cloth from the bucket on the counter and wipe off the food prep table. Cook #1 took the container of test strip paper, labeled "Phydration" and stuck the orange colored paper in the bucket of solution being used. The paper was held in the solution under 5 seconds. When the test strip was removed, the color remained the same orange color as prior to the strip being placed in the solution. The result was read by Cook #1 as 100 PPM (parts per million). He indicated this bucket of solution had been poured 2 1/2 hours ago and the level of sanitation solution should be between 100 and 200 PPM.</p> <p>On 5/11/11 at 9:25 A.M., Dishwasher #1 was interviewed regarding the 3 compartment sink. He indicated the first sink contained soapy water for soaking items, the second sink was the rinse sink and the third sink is where staff filled</p>				<p>Completion Date 6-10-2011</p> <p>FSM/Designee will monitor sanitizing solution stock weekly x 12 weeks. FSM/ Designee will also monitor sanitation cleaning buckets as well as the sanitizer in the 3 compartment sink 2 times a day for 2 weeks and then 1 time a day for 2 weeks. Random checking of sanitizing levels will be done by FSM/Designee for another 5 months. Results will be brought to QA monthly for review and recommendations if needed.</p> <p>Completion Date 6-10-2011</p> <p>The dishwasher has been checked by the appropriate vendor to ensure the proper temperature can be maintained for sanitation of our dishes.</p> <p>Completion Date 6-10-2011</p> <p>All dietary staff have been in-serviced on the proper wash and rinse temperatures for the dish machine and who to call for assistance if temperatures are too low.</p> <p>Completion Date 6-10-2011</p> <p>The yellow pudding like substance that was unlabeled was thrown away. The roast type ham in the refrigerator that was dated 5-5-2011 was also thrown away. The roast beef that was partially opened and unlabeled was thrown away. The turkey that was opened and undated was thrown away. The bologna that</p>		

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	<p>their buckets with the sanitizing solution. The first sink was observed to have soapy water in it with various cooking pans in it, sticking up out of the water. The second sink was also filled with clear water as well as the third sink, also filled with clear liquid. Dishwasher #1 explained how the sanitizer is dispensed by a hose on the wall connected to a bottle of sanitizer. Viewing the bottle of sanitizer was obstructed as there were dish racks stacked up in front of it. Upon request, Dishwasher #1 was asked to test the strength of the sanitizer level in the 3rd sink. He took the test strips, labeled Phydration, and took the orange strip of paper and stuck it in the 3 compartment sink. He indicated he was to hold the strip in the water for 10 seconds. When he removed the test strip, it was the same orange color as when he removed it from the dispenser. Dishwasher #1 indicated they "were low on sanitizer." When the dispensing tube was followed along the wall, behind the stacked dish racks, an empty metal holder was observed. He indicated someone had "gone to get more" sanitizing solution.</p> <p>On 5/12/11 at 3 P.M., a copy of the May 2011 "Dishwasher Temp (temperature log) was received from the Administrator. This form had dishwasher temperatures documented for each of the 3 meals a day</p>				<p>was in the resealable package and had the date that had been torn through was thrown away. The vegetable soup that had no label was also thrown away. The reddish pool of liquid under the meat tray on the floor was cleaned and sanitized appropriately.</p> <p>The bag of frozen unlabeled fish was thrown out of the freezer. The speed racks in the refrigerator that were moved to get to the freezer had jello that spilled on the floor of the walk in refrigerator as they were moved. It was immediately cleaned up. The bowl of shrimp that was undated and unlabeled was thrown out.</p> <p>Plastic wrap was ordered and quantity and availability will be maintained by the FSM/ Designee. Food on the speed racks will be covered with plastic wrap. Completion Date 6-10-2011</p> <p>All dietary staff will be in-serviced on proper food storage procedures of food in the refrigerators as well as the freezers. The dietary staff will also be in-serviced on proper handling and usage of leftover foods. Completion Date 6-10-2011</p> <p>FSM/ designee will monitor the refrigerators and freezers daily x 6 months to ensure proper storage of food and leftovers is being done. The results of this monitoring will be forwarded to the QA committee for</p>		

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	<p>to date. Of the 36 rinse temperatures logged, 8 were documented to be below 180 degrees Fahrenheit. The low temperatures ranged from 170 - 179 degrees Fahrenheit.</p> <p>On 5/16/11 at 12 P.M., the Regional Representative [RR] was interviewed. He indicated the rinse temperature of the dishwasher should be at least 180 degrees Fahrenheit. He indicated that kitchen staff "have not been educated enough to be aware of required temperatures."</p> <p>2. During initial tour of the kitchen, on 5/9/11 at 9:30 A.M., Cook #2 entered the walk in refrigerator. He lifted a single serving bowl of a yellow pudding like food from the shelf. This bowl was not labeled. Cook #2 was unable to identify what was in the bowl. A roast type ham was observed on one of the shelves. Cook #2 indicated the date on the ham (which he identified to be approximately 3 pounds) had a date of 5/5/11. Cook #2 indicated this ham should have been thrown out on 5/8/11, as they keep potentially hazardous foods for only 3 days. A package of roast beef, identified by Cook #2 to be approximately 3-4 pounds, was partially covered with plastic wrap. Cook #2 indicated this roast beef was lacking a date. A package of turkey meat (2 ounces) was opened but not dated</p>				<p>further recommendations if needed. Completion Date 6-10-2011</p> <p>All unpasteurized were thrown out. Staff was in-serviced on the policy of serving unpasteurized eggs. Completion Date 6-10-2011</p> <p>FSM/Designee will continue to monitor food orders to ensure the availability of pasteurized eggs to cook. Completion Date 6-10-2011</p> <p>Thermometers have been placed in all refrigerators and freezers per policy. All dietary staff including our regional representative have been in-serviced on where the thermometers are located as well as safe temperature ranges for the freezer and refrigerators. Each dietary staff member has been in-serviced on where to record daily temps and who to contact if temperatures are not within range. The in-service included the disposal of food that ever encounters out of range temperatures. Completion Date 6-10-2011</p> <p>All food in the stand up freezer was disposed of. A freezer log was placed on the outside of the stand up freezer. Maintenance was called to check the temperature problem in the freezer. The freezer was fixed. Completion Date 6-10-2011</p> <p>All equipment has been pulled out</p>		

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	<p>as to when it was opened. An opened package of bologna was also observed. This was in a resealable package but was not dated as to when it was opened and the use by date on the package was unable to be read as it had been torn through. A sheet pan was observed in the walk in refrigerator with an uncut baked cake in it. The cake was not covered or dated. A 15 quart container was observed with vegetable soup in it. This container was undated. Cook #1 indicated the soup had been made yesterday. A pool of a reddish liquid type substance was observed around the base of a leg of one of the shelves in the walk in refrigerator. The diameter of the pooled reddish liquid was at least 5 inches and was drying on the edges. Directly above the reddish pool, was a case of beef, placed directly on the metal shelving.</p> <p>At 9:45 A.M., the walk in freezer was observed. A bag of frozen, unbreaded fillet type fish was observed. The fish was in a bag, which Cook #2 identified as not having a date, and observed that the bag was not sealed, but had a hole, at least 6 inches in diameter in the exposed side of the bag. The bag was not labeled as to its contents.</p> <p>At 1:30 P.M., Cook #2 indicated he was going to dispose of the fish fillets in the</p>				<p>and the floors have been cleaned including the edges. Completion Date 6-10-2011</p> <p>The hand washing sink has been thoroughly cleaned and the trash can removed with a new one placed by the hand washing sink. All spatters on the walls have been wiped clean. All shelves have been cleaned as well as a new microwave purchased and the old stained one thrown out. Completion Date 6-10-2011</p> <p>The staff have been in-serviced on the proper way to keep trash contained and the trash overflowing in the trash can was taken out. Completion Date 6-10-2011</p> <p>The staff have been in-serviced on how to properly wash the floor mats in the dish room. They have also been in serviced on proper use of the three compartment sink and cross contamination. Completion Date 6-10-2011</p> <p>All staff will be in-serviced on the washing of the hand sink as well as the 3 compartment sink. Completion Date 6-10-2011</p> <p>Cleaning schedules have been posted and staff has been in serviced on their individual responsibilities for kitchen sanitation. Completion Date 6-10-2011</p> <p>FSM/designee will monitor the cleaning schedules daily x 6 months</p>		

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	<p>walk in freezer in the opened bag. Cook #2 was in the walk in refrigerator and moved a standing, wheeled rack with large uncovered, pans of red liquid in them. When Cook #2 moved the rack, the wheel stuck and the pans of red liquid spilled and spattered on the floor of the walk in refrigerator.</p> <p>A covered bowl of cooked shrimp was observed at 2 P.M. on the bottom shelf of the walk in refrigerator. This shrimp was not dated. The bowl had water in it and that pan was placed in a pan with ice in it. The temperature of the shrimp was 30 degrees. Cook #1 indicated the pre cooked shrimp had been thawed in the refrigerator in the package yesterday and when they were thawed, water was added.</p> <p>On 5/10/11 at 8:20 A.M., the reddish liquid observed pooled at the base of the shelf leg in the walk in refrigerator was again observed. The reddish puddle was approximately 6 inches in diameter.</p> <p>At 8:20 A.M. on 5/10/11, Cook #3 was interviewed regarding ham in the walk in refrigerator. She indicated the chunk of ham was about 3 pounds. The cut ham was covered with plastic wrap but was not dated. She indicated the ham had been opened yesterday. She removed the ham from the refrigerator and placed it in a</p>				<p>to ensure staff is performing assigned duties. Audits will be forwarded to the QA committee for further review and recommendation as needed. Completion Date 6-10-2011</p> <p>Staff has been in serviced on the use of hair restraints in all kitchen food prep areas. Hair restraints have been placed outside the dining room so staff other than dietary that need to enter the kitchen may do so with a hair net in place. Completion Date 6-10-2011</p> <p>Overall sanitation will be monitored by the FSM/Designee on a weekly basis through a sanitation score card checklist. Sanitation checks will be completed weekly for 6 weeks and then months thereafter for 10 months with the results being forwarded to the QA committee for further review and recommendations as needed. Completion Date 6-10-2011</p>		

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	<p>plastic container and dated it.</p> <p>At 9 A.M., Cook #3 toured the walk in freezer. The opened bag of frozen fillet type fish remained in the walk in freezer. Cook #3 threw the opened bag of frozen fish away.</p> <p>On 5/11/11 at 8:30 A.M., the walk in refrigerator was observed. The reddish puddle remained around the same leg of shelving as observed on 5/9/11 and 5/10/11.</p> <p>On 5/11/11 at 11:45 A.M., the RR provided a copy of the undated policy and procedure for "Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance." The procedure, included but was not limited to, the following: "Food is covered, dated and stored loosely to permit air circulation...Prepared perishables such as...puddings...are stored in a refrigerator and covered, labeled and dated until used...left overs are refrigerated immediately and used within 72 hours or frozen...All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers to prevent freezer burn. Items are labeled and dated.</p> <p>On 5/11/11 at 3:08 P.M., the kitchen was</p>						

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	<p>toured with the RR. At this time, Cook #2 was asked by the RR to cover the pans of carrot salad which were observed in the walk in refrigerator on standing racks uncovered. Cook #2 indicated they didn't have any plastic wrap. The carrot salad was then covered with cookie sheet type pans.</p> <p>On 5/12/11 at 11 A.M., the RR was interviewed. He indicated "we have really fallen short on giving them (staff) the tools they need to succeed." He indicated inservicing had begun on that date.</p> <p>On 5/12/11 at 11:30 A.M., the RR provided a copy of the policy and procedure for "Leftover foods will be utilized in an appropriate and safe manner to aid in controlling waste." This policy was undated. The procedure included, but was not limited to, the following: "...Leftovers should be covered, dated, labeled...as soon as meal service is finished...leftovers which are frozen are covered so they are air-tight and moisture proof. They are labeled with item and date...The Dining Service Manager or cook checks for leftovers each morning and determines how to use them..."</p> <p>3. During initial tour of the kitchen on 5/9/11 at 9:30 A.M., the walk in refrigerator was observed. Five boxes of</p>						

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	<p>18 count eggs were observed. Cook #2 indicated these eggs had just been bought from a local grocery, as they had run out of eggs and the eggs were not pasteurized. He indicated they were getting a food order in on that day.</p> <p>On 5/11/11 at 8:40 A.M., Cook #1 was observed in the kitchen. A container housing shelled eggs was observed on the counter. No markings were observed on these eggs. At this time, Cook #1 took two of the shelled eggs from the counter, cracked them and put them in a hot skillet. He then put them on a plate with additional breakfast food and started to walk out of the kitchen. At that time he was interviewed. He indicated the eggs he just cooked were not pasteurized and were cooked with the whites to a medium. He stated the yolks were not hard cooked. Cook #1 indicated that sometimes they run out of eggs and buy them. He indicated he thought if the whites were cooked over medium it was OK to serve them. At this time Cook #3 was interviewed. She indicated she thought unpasteurized eggs had to be cooked hard. Cook #1 then threw the medium cooked eggs out.</p> <p>On 5/11/11 at 2 P.M., the RR provided a copy of the Policy and procedure for "safe and sanitary handling of food will be</p>						

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	<p>employed during food production." This policy was undated. This policy included, but was not limited to, the following: "only pasteurized raw eggs are served."</p> <p>On 5/12/11 at 11:A.M., the RR was interviewed. He indicated that all eggs should be pasteurized. He indicated they were in a "situation where they ran to store and bought other (non pasteurized) eggs."</p> <p>4. During initial tour of the kitchen on 5/9/11 at 9:45 A.M., the walk in freezer was observed. Cook #2 was looking for the thermometer to read the current temperature. Cook #2 was unable to find a thermometer in the walk in freezer.</p> <p>A form titled "Refrigerator/Freezer Temp Log" was observed on the outside of the walk in refrigerator/freezer door. This log had no date for the "Month"on the form but was completed through the ninth of the month. The temperature for each entry for the walk in freezer was "-11."</p> <p>At 9:50 A.M., the milk cooler was observed. Cook #1 was unable to locate a thermometer to check the current temperature in the cooler.</p> <p>At this time, the temperature to the stand up freezer was read by Cook #2 as 31</p>						

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	<p>degrees (Fahrenheit). There were 5 large, 3 gallon drums of ice cream. One of the containers had a paper lid, which was not sealing the ice cream closed. Three fourths of the paper lid round was separated from the edge, thus exposing ice cream The container had approximate 1/3 of the ice cream missing. The ice cream was observed to be melting, with soft mushy ice cream observed from the inside edge of the container, at least 1 inch in toward the center of the container. Fluid ice cream was observed in the center of the ice cream. Cook #2 threw this drum of ice cream away. All 5 drums of ice cream were soft enough to be able to be pushed in when touched from the outside of the container. One of the other unopened containers of ice cream was opened with the same degree of melting observed as above, with mushy ice cream observed at least 1 inch in from the inside edge of the container. Cook #2 indicated "this shouldn't be" and thought maybe the freezer was in defrost mode. He notified the maintenance man of the freezer. While waiting for the maintenance man, Cook #2 began emptying the stand up freezer. He removed the following: 4 remaining drums of ice cream; a case of 48 count "magic cup" food items, with approximately 10 magic cups missing (when pushed on one of the lids of the magic cup, the melted substance emerged</p>						

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	<p>from the edges of the lid); 3 pre packaged cream pies; 2 cases of 50 count, 4 ounce servings, of mighty shakes and one 75 count case of 4 ounce mighty shakes was also removed from the freezer. These cartons were able to be pushed on the sides when felt. Cook #2 indicated the food items shouldn't be soft. A single carton of mighty shake was removed from the back of the freezer and was frozen solid when the carton was touched. At 10:05 A.M., the above items were moved to the walk in freezer on a cart. Also removed from the freezer were 3 boxes of 40 count cookies; one prepackaged cheesecake, chocolate layer cake (prepackaged); and 4 prepackage loaf pound cakes. An angel food cake was observed to have one, one inch slice missing. This angel food cake was not completely covered, was not dated and was also observed to be soft.</p> <p>On 5/9/11 at 11 A.M., a copy of the "Refrigerator Temp (temperature) log was received from the a This is the log which hung in the kitchen on the refrigerator/freezer. This log was completed for The "month" area was left blank. The categories form included the following: "walk in refrigerator freezer; reach in refrigerator; milk cooler." Doc was lacking on this form of an area to document freezer temperatures.</p> <p>On 5/9/11 at 11:30 A.M., the temperature</p>						

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	<p>of the milk was checked on the second floor Transitional Care Unit dining room by Dietary Assistant #1. She indicated the one gallon plastic jug of reduced fat milk was sitting in a plastic tub of ice. She checked the temperature of the milk from the gallon jug with a kitchen thermometer and read the temperature to be 60 degrees Fahrenheit. She then stated "that shouldn't be" and threw the gallon of milk away. She indicated the milk had not been "buried far enough in the ice."</p> <p>On 5/9/11 at 1:32 P.M., the temperature of the stand up freezer was observed to be 8 degrees F. The freezer was empty at the time.</p> <p>On 5/11/11 at 11:45 A.M. a copy of the policy and procedure for "Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance." This policy was undated. The procedure included, but was not limited to, the following: "Thermometers are placed in every refrigeration unit so as to be easily visible for checking and in the upper third part of the front of the storage unit. Temperatures will be recorded on the Refrigerator log at least twice a day...Frozen storage temperatures will be at 0 degrees F (Fahrenheit) or below...Temperatures will be recorded on</p>						

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	<p>the Freezer Temperature log at least twice a day."</p> <p>Documentation was lacking of the reach in freezer temperature being monitored at all and/or any refrigerator and/or freezer having had temperatures monitored twice a day.</p> <p>On 5/11/11 at 2:50 P.M. a tour was conducted with the Facilities Regional Representative (Rep.) (RR). In the main dining room, located directly off the kitchen, the RR was unable to locate log, documenting the temperature was being monitored in this refrigerator.</p> <p>At 3:08 P.M., the walk in freezer was toured with the RR. He was unable to find a thermometer.</p> <p>At 3:13 P.M., the milk cooler was toured with the RR. He was unable to find a thermometer in the milk cooler.</p> <p>On 5/16/11 at 2 P.M., the Administrator indicated on the evening of 5/8/11, the Dietary staff left the department about 10 P.M. She indicated when the dietary staff arrived the morning of 5/9/11, the temperature in the reach in freezer was 60 degrees Fahrenheit. She indicated she was informed that the door to the reach in freezer had not closed properly the</p>						

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	<p>evening of 5/8/11, the fan froze up to the reach in freezer, thus leading to the increased temperature.</p> <p>5. During initial tour of the kitchen, on 5/9/11 at 9:20 A.M., the following was observed:</p> <p>The flooring of the kitchen was observed to have scattered dust, debris and bits of food items, especially along the wall edges and around the legs of tables and appliances.</p> <p>The only hand wash sink was observed with the following: in the base of the sink was a small brush and a sponge with seeds on it. The basin of the sink was observed to have brownish areas of residue scattered throughout. The same brownish residue was observed along the top edges of the faucet fixture and along the edges of the sink. The wall behind the sink was observed to have various splatters throughout up to chest level on the wall. The hand wash sink was located next to a covered, foot pedal operated trash can. The lid to this trash can was heavily laden with various splatters of dried substances. The trash can was sitting in a corner. The walls on the back and side of the trash can were also laden with splatters of dried substances, from chest height on the wall down.</p>						

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	<p>The open shelf underneath the sink in the cooking area was observed. This shelf had at least 2 buckets of sanitizer solution on it. Throughout the shelf were areas of dark black brown sticky residue .</p> <p>The microwave was observed to have dried splatters of a light substance on the outside of the oven. When opened, the based of the microwave was observed to have a very dark, blackish colored substance. This substance covered the front half of the oven bottom, extending back from the edge at least 2 inches. Dried splatters were also observed throughout the microwave. This black substance was able to be scraped off.</p> <p>The large wheeled trash can was observed, at 1:10 P.M. in the cooking area and the dishwashing area, to be overflowing and without a lid.</p> <p>On 5/10/11 at 8:20 A.M., the hand wash sink was observed again. The small brush remained in the sink basin as observed on 5/9/11. The condition of the sink, walls and covered trash can also remained the same as observed on 5/9/11.</p> <p>On 5/10/11 at 8:20 A.M., the floor condition, shelf condition and the microwave remained the same as</p>						

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	<p>observed on 5/9/11.</p> <p>On 5/11/11 at 9 A.M., the microwave was again observed. The dried spatters to the outside and the dark substance to the inside remained as observed on 5/9/11 on initial tour.</p> <p>On 5/11/11 at 9:10 A.M., the hand wash sink was again observed. The small brush remained in the sink basin as observed initially on 5/9/11. The condition of the sink, walls and covered trash can also remained the same as observed on 5/9/11.</p> <p>On 5/11/11 at 9:10 A.M., the open shelf under the sink in the food prep area remained the same as observed on 5/9/11 at 9:20 A.M.</p> <p>On 5/11/11 at 11:15 A.M., Dishwasher #2 was observed in the dish room. Dishwasher #2 picked up a rubber mat from the floor and placed it on the dirty dish work space. The rubber floor mat was laying flat and he then took the dish water nozzle with a brush on the end of it and began scrubbing the rubber floor mat. This is the same dish water nozzle observed to cleanse dirty dishes prior to being run through the dishwasher. He then rolled the rubber floor mat up and placed it in the second compartment of the three compartment sink, where there was</p>						

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	<p>another black rubber floor mat rolled up. He then began scrubbing the dish area floor and walls with a brush/broom.</p> <p>At 11:40 A.M. on 5/11/11, Dishwasher #2 began running water into the second compartment of the 3 compartment sinks. The rubber mats had been replaced to the floor. Dishwasher #1 was interviewed. He indicated they clean the sink twice a shift and it was cleaned right after breakfast. He indicated he had not cleaned the 3 compartment since after breakfast.</p> <p>At 12:15 P.M. on 5/11/11, a pan was observed soaking in the 2nd compartment of the 3 compartment sink.</p> <p>At 12:15 P.M., Dishwasher #1 was interviewed. He indicated they were out of sanitizer solution. He indicated they had some for breakfast but were out at that time.</p> <p>At 12:20 P.M., the RR returned with sanitizer solution and indicated, "this will be hooked up right now."</p> <p>At 12:20 P.M. Dishwasher #2 was interviewed. He indicated he had not washed any of the 3 compartment sinks today.</p>						

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	<p>On 5/11/11 at 4:55 P.M., the RR was interviewed. The RR indicated the FSM and the AFSM monitored kitchen sanitation and he monitored them.</p> <p>On 5/12/11 at 9:45 A.M., the kitchen was toured with the RR. The condition of the sink remained as observed on 5/9/11, 5/10/11 and 5/11/11. The RR indicated the brush, lying in the base of the sink, was probably used to clean employees' fingernails with.</p> <p>On 5/12/11 at 11:30 A.M., the RR was interviewed. He indicated he was unable to locate any completed documented cleaning schedules for the kitchen. He indicated the last completed cleaning schedule was done before the FSM left.</p> <p>On 5/12/11 at 11:45 A.M., the Policy for "The handwashing sink will be cleaned and sanitized on a routine basis according to defined procedures" was reviewed. This policy was dated 2009 and was received from the RR at the time of review. Documentation was lacking as to the specification of "routine basis" regarding frequency of cleaning.</p> <p>On 5/12/11 at 12:20 P.M., blank copies of the daily, weekly and monthly cleaning schedules were received. Daily Tasks included, but were not limited to, the</p>						

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	<p>following: "3 well sink, each use; hand sink; juice machine each meal; microwave; floors sweep/mop; work table cooks area; work tables serving area."</p> <p>6. On initial tour of the kitchen, on 5/9/11 at 9:20 A.M., the kitchen was observed in the following manner: The one main entry door to the kitchen was from the main dining room. The one main walk way from the front of the kitchen to the back, went directly by the food prep table area. The food prep/cook area was located directly in the kitchen off to the left of the main walk way. Staff were observed, at the time, to walk into the kitchen without hair restraint on and place "meal tickets" (with residents' food orders on them) on the side of the ice machine. The ice machine was also located across a walkway from the shorter side of the food prep table.</p> <p>On 5/9/11 at 10:15 A.M., the Administrator was observed walking into the kitchen without a hair restraint in place. At the time she walked by the food prep table, uncovered chicken breasts were on the counter being prepared.</p> <p>On 5/9/11 at 12 P.M., Physical Therapy staff #1 was observed inside the kitchen door without a hair restraint on. Meal preparation was in progress at the time.</p>						

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	<p>On 5/11/11 at 8:15 A.M., the SSD (social service director) entered the kitchen without hair restraint on. She walked in the front door of the kitchen, through the main walk way, by the food prep area and walked to the back of the kitchen.</p> <p>On 5/11/11 at 8:20 A.M., LPN #1 entered the kitchen without a hair restraint on. He took a meal order ticket, entered the kitchen went over to the ice machine stating "order in" and stuck the order ticket on the side of the ice.</p> <p>On 5/11/11 at 9 A.M., the Maintenance Supervisor, accompanied by an outside service worker walked through the main walk of the kitchen. The service worker did not have any hair restraint on. The Maintenance Supervisor was observed with a ball type cap on.</p> <p>On 5/12/11 at 11:30 A.M., the RR was interviewed. He indicated anyone going through the kitchen area should have a hair restraint on. He also indicated the food prep area was along the only path through the kitchen from front to back.</p> <p>On 5/12/11 at 11:45 A.M., the undated policy and procedure for "Nutrition Services Department employees will dress appropriately and practice good hygiene"</p>						

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	<p>was received from the RR. The policy included, but was not limited to, the following: "The organization has strict requirements regarding hair: Employees will wear hairnets that COMPLETELY covers the hair while in the kitchen or serving food."</p> <p>The Administrator provided a Census sheet, on 5/9/11 at 11:00 a.m., indicating 52 residents resided on the skilled units in the facility.</p> <p>3.1-21(i)(3)</p>						

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview, and record review the facility failed to ensure a nurse washed her hands after removing her gloves, during dressing changes, for 1 of 1 sampled resident observed during a</p>			F0441	<p>F 441</p> <p>Res #36, 38, and 23 suffered no ill effects from the findings on the 2567.</p> <p>Completion Date 6-10-2011</p>		06/10/2011

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	<p>dressings change, in the sample of 13, and for 1 of 1 supplemental sample resident observed during a dressing change, in the supplemental sample of 9. (Residents #38, #36)</p> <p>B. Based on record review and interview, the facility failed to ensure 1 of 13 sampled residents had a tuberculosis skin test given upon admission. (Resident #23)</p> <p>Findings include:</p> <p>A1. During initial tour on 05/09/11 at 9:50 A.M., Resident #38 was identified by the DoHS [Director of Health Services] as interviewable and having a wound vac applied to the right outer calf for a stasis ulcer.</p> <p>The clinical record of Resident #38 was reviewed on 05/11/11 at 4:30 P.M.</p> <p>The ADoHS [Assistant Director of Health Services] was observed, on 05/10/11 at 9:15 A.M., to change the wound vac dressing to Resident #38's right outer calf. The ADoHS was observed to perform handwashing, don gloves, and gather the necessary supplies to change the wound vac dressing. The ADoHS was observed to doff [remove] gloves and don clean gloves without performing handwashing</p>				<p>All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure correct actions to prevent spread infection are followed. Completion date 6-10-2011</p> <p>Nursing staff will be in serviced on proper hand washing procedures, glove usage, and proper precaution techniques to prevent spreading of infection Systemic change will be that nursing staff will have return demonstration of skills to prevent infection including hand washing and glove application. Skills will be re-evaluated on an annual basis for competency. Nursing staff have been in serviced on TB skin test policy and procedures. Systemic change ADHS has been trained as a TB instructor. Completion Date 6-10-2011</p> <p>DHS/Designee will monitor 3 random residents for resident care that includes hand washing, glove usage, and care provided to ensure preventive infection control practices followed 5x week x one month 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further</p>		

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	<p>or using anti-microbial gel. The ADoHS was observed to remove the old dressing, doff gloves, and don clean gloves without performing handwashing or using anti-microbial gels. The ADoHS was then observed to clean the peri-wound, doff gloves, and don clean gloves without performing handwashing or using anti-microbial gel. The ADoHS then cleansed the wound, doffed gloves, and donned clean gloves without performing handwashing or using anti-microbial gel. The ADoHS was then observed to apply clean primary dressing to the wound bed, doff gloves, and don clean gloves without performing handwashing or using anti-microbial gel. The ADoHS was then observed to apply the secondary dressing over the wound, doff gloves, and don clean gloves without performing handwashing or using anti-microbial gel. The ADoHS was then observed to doff gloves and perform handwashing.</p> <p>A Progress Note, completed by the Nurse Practitioner and dated 05/10/11, indicated, "RLE [Right lower extremity] calf wound...distal end of wound dark colored wound edges hardened faint foul odor noted today..." The Progress Note further indicated, "Changed frequency of 3X wk [three times a week]."</p> <p>A Policy and Procedure, provided by the</p>				<p>suggestions/comments</p> <p>DHS/designee will review all new admissions in am clinical meeting to assure TB skin test was administered per policy 5x week x one month 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments Completion Date 4-2-2010</p>		

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	<p>ADoHS on 05/11/11 at 2:30 P.M., indicated, "Handwashing is the single most important factor in preventing transmission of infection. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF [Long Term Care Facility]... 3. Health Care Workers shall wash hands at times such as: ...d. After removing gloves, ...for direct contact with excretions or secretions, ...resident equipment..."</p> <p>In an interview with the ADoHS, on 05/11/11 at 2:30 P.M., she indicated, "You wash your hands before and after a treatment and if you change gloves you should wash your hands."</p> <p>A2. On 5/9/11 at 3:25 p.m., the Assistant Director of Health Services [ADoHS] was observed doing a treatment to Resident #36's lower legs. She washed her hands and donned gloves, removed the soiled dressings from the right leg, changed gloves, cleansed the areas, changed gloves, applied clean dressings to the areas. She then changed gloves, removed the soiled dressings from the left lower leg, changed gloves, cleansed the areas, changed gloves, applied clean dressings, removed gloves and then washed her hands. There was no handwashing between glove changes.</p> <p>B1. During initial tour, on 05/09/11 at</p>						

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	<p>10:10 A.M., Resident #23 was identified by the ADoHS as interviewable and a new admission from the hospital. Resident #23 was observed at that time sitting in a chair in her room.</p> <p>The clinical record was reviewed, on 05/10/11 at 10:00 A.M., and indicated Resident #23 was admitted to the facility on 04/06/11.</p> <p>The Immunization Record, dated 04/07/11, indicated Resident #23 received a Tuberculosis test on 04/07/11.</p> <p>The TB Screening: Residents policy and procedure, provided by the DoHS on 05/16/11 at 9:30 A.M., indicated, "Policy All resident [sic] either prior to or upon admission, ...will receive a 2-Step Mantoux test for tuberculosis...Mantoux Test:... Residents, Admission, Two-Step, Administer on or before day of admission..."</p> <p>In an interview with the DoHS, on 05/11/11 at 4:50 P.M., she indicated, "She [Resident #23] didn't get it [the tuberculosis test] until 04/07/11. We should have done one on admit."</p> <p>3.1-18(e) 3.1-18(l)</p>						

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F0518 SS=E	<p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>Based on observation, record review and interview, the facility failed to ensure laundry supervisory staff and/or laundry staff were trained on department emergency procedures, for 1 of 1 laundry Supervisor, and for 2 of 2 laundry staff interviewed regarding emergency procedures. This deficient practice had the potential to affect 52 residents residing on the skilled units in the facility. (Laundry Supervisor, Laundry Staff #1, Laundry Staff #2)</p> <p>Findings include:</p> <p>On 5/12/11 at 2:30 P.M., a tour of the Laundry was conducted with the Supervisor. She indicated the 2 large, industrial size dryers, were gas dryers. Regarding the location of the gas shut off valve, the Laundry Supervisor indicated, she "didn't know the answer" and they had recently installed a door giving access to the area behind the dryers. She indicated</p>			F0518	<p>F 518</p> <p>No residents suffered any ill effects from the deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice and through the in-servicing of all laundry staff, fire policies and procedures will be learned and practiced through regular drills. Completion Date 6-10-2011</p> <p>All laundry staff will be in-serviced and trained on fire safety in the laundry area. Each laundry staff member will be required to demonstrate the use of a fire extinguisher and verbalize the placement of the fire pull in the laundry area and the building's gas shut-off valve. Completion Date 6-10-2011</p> <p>Drills will be performed that include scenarios where the gas shut-off valve will need to be accessed and turned off. Completion Date 6-10-2011</p>		06/10/2011

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	<p>she "wanted to say it's (gas shut off valve) there but I don't know." She indicated, for an emergency, staff are to pull the breaker for the washers, located behind the washers. She indicated for emergency procedures for the dryers, "we probably do (have shut off valves) for the dryers but I don't have the answer for that. I've been here 7 years, not needed that before."</p> <p>At 2:40 P.M., the Laundry Supervisor was asked to open the door (the one she indicated she thought provided access to the emergency shut off valve to the dryer) in the laundry. The door was locked. She took out her key chain and tried to unlock the door. She indicated she did not have the key to unlock the door. She indicated she would page the maintenance man to come and unlock the door. At 2:41 P.M., she got on the phone and asked another staff member to page (maintenance Supervisor name). At this time, she indicated she was not sure of the location of the emergency fire pull for the department. She indicated she "had never been asked that before." She indicated she supervised 10 staff members.</p> <p>At 2:47 P.M., she got on the phone again and had the maintenance man paged again by a staff member. She indicated from that phone, they did not have the capability to page the maintenance</p>				<p>A key to the door that leads to the back of the dryer will be placed on a hook outside the dryer enclosure. Laundry staff will be trained on when they would need to access the gas shut-off behind the dryers versus the main building's gas shut-off. Completion Date 6-10-2011</p> <p>ED/ Designee will randomly ask 20 employees a week on various shifts for 4 weeks to demonstrate where to shut off gas to the building in case of a fire. ED/ designee will then randomly ask 10 employees a week on various shifts for 4 weeks to demonstrate where to shut off gas to the building in case of a fire. Results will be forwarded to the QA committee monthly x 2 months for review and further suggestions. Completion Date 6-10-2011</p>		

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	<p>Supervisor directly overhead, but needed to call another department to page the maintenance Supervisor. She indicated she could call the maintenance office but if no one was there, she would have to call another department and have them page the maintenance Supervisor for her.</p> <p>At 2:50 P.M., the Maintenance Supervisor arrived to the department. He indicated the 2 dryers were gas dryers. He stated that he and the assistant maintenance man were the only ones with keys to the door with access to the emergency gas shut off valve. He indicated the door enclosing the gas shut off valve had been in place for 1 year.</p> <p>On 5/12/11 at 4:15 P.M., the Administrator was interviewed. She indicated the maintenance Supervisor told the staff where the emergency shut off valve was during orientation.</p> <p>On 5/12/11 at 4:30 P.M., the Administrator provided a copy of a form titled "Environmental Tour." She indicated this was the information the maintenance man provided to new employees during orientation. The "tour" included, but was not limited to, the following: "Electrical and Gas shut offs". The Administrator indicated at that time, the main shut off valve to the gas dryers</p>						

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	<p>was outside by the generator. In the event of a fire, staff would turn the gas off by the outside access. The Administrator also indicated, at that time, a key had been placed in the laundry room to give staff access to the locked gas shut off valve located in the laundry department.</p> <p>On 5/16/11 at 8:30 A.M., the Administrator was interviewed. She indicated Laundry Staff #1 was the most recently hired staff in the Laundry department.</p> <p>On 5/16/11 at 8:30 A.M., Laundry Staff #2 was interviewed. She indicated she had been hired to the department in 2004. She indicated, in the event of a fire, she would take the key, which is now hanging by the door (to gain access to the gas shut off valve located behind the dryers). She indicated to turn off the gas shut off valve behind the dryers, she would pull up on the knob, located behind the door/dryers. Laundry Staff #2 indicated this was the only place she was aware of to turn off the gas shut off valve, behind the dryers. She indicated if there was a fire in her department, she would go up to the front of the building to let them know of a fire. She was unable to find a fire pull alert station in the laundry department. She indicated there was one fire extinguisher in the department. She indicated she was</p>						

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	<p>trained several years ago on how to use the fire extinguisher. Laundry Staff #2 indicated "when they do the training, I'm already gone for the day." She indicated she leaves for the day at 1 - 1:30 P.M.</p> <p>On 5/16/11 at 8:45 A.M., the Maintenance Supervisor was interviewed. He indicated if there was a fire in the laundry, he instructed/expected the staff to come to the main gas shut off valve, located out the back door from the laundry and around the corner of the building. He indicated there was no written policy and procedures for fire specific to the laundry department. He indicated the shut off valve turned gas off for the entire building. The valve was labeled, "gas shut off valve." The Maintenance Supervisor indicated that if there was a fire, even in the washer area/clean part of the laundry department, he would expect staff to come outside and turn off the gas shut off valve. He indicated inservices were done yearly regarding fire policy and procedures for all staff.</p> <p>On 5/16/11 at 8:50 A.M., the Maintenance Supervisor (MS) provided a copy of the material he reviewed at the staff annual inservicing. The MS indicated the annual inservicing was done around the middle of the year and was mandatory for all employees. At that</p>						

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R0000	<p>time, the MS provided a copy of the information he shared at the annual staff inservicing. This included, but was not limited to, the following: "Fire Safety Pre/Post test; Fire safety - When the fire alarm sounds, and Fire Safety - Fire Drill Procedures."</p> <p>The Administrator provided a copy of a Census sheet, on 5/9/11 at 11:00 a.m., indicating 52 residents resided on the skilled units at the facility.</p> <p>3.1-51(b)</p> <p>The following Residential Findings were cited in accordance with 410 IAC 16.2-5.</p>			R0000	<p>The submission of this plan of correction does not indicate an admission by River Pointe Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of River Pointe Health Campus. This facility recognizes it's obligation to provide legally and medically necessary care and services to it's residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the</p>		

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					requirements of participation for comprehensive health care facilities.(for Title 18/19 programs)To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements govnrning the management of this facility. It is thus submitted as a matter of statute only.		

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R0119	<p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</p> <p>(A) aged;</p> <p>(B) developmentally disabled;</p> <p>(C) mentally ill;</p> <p>(D) dementia; or</p> <p>(E) children;</p> <p>served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including:</p> <p>(A) organization chart;</p> <p>(B) personnel policies;</p> <p>(C) appearance and grooming policies for employees; and</p> <p>(D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on observation, record review and interview, the facility failed to ensure laundry Supervisory staff and/or laundry staff were trained on department emergency procedures, for 1 of 1 laundry Supervisor, and for 2 of 2 laundry staff</p>			R0119	<p>R 119</p> <p>No residents suffered any ill effects from the deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice and through the in-servicing of all</p>		06/10/2011

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	<p>interviewed regarding emergency procedures. This had the potential to affect 40 residents on the Assisted Living Units [Residential level of care]. (Laundry Supervisor, Laundry Staff #1, Laundry Staff #2)</p> <p>Findings include:</p> <p>On 5/12/11 at 2:30 P.M., a tour of the Laundry was conducted with the supervisor. She indicated the 2 large, industrial size dryers, were gas dryers. Regarding the location of the gas shut off valve, the Laundry Supervisor indicated, she "didn't know the answer" and they had recently installed a door giving access to the area behind the dryers. She indicated she "wanted to say it's (gas shut off valve) there but I don't know." She indicated, for an emergency, staff are to pull the breaker for the washers, located behind the washers. She indicated for emergency procedures for the dryers, "we probably do (have shut off valves) for the dryers but I don't have the answer for that. I've been here 7 years, not needed that before."</p> <p>At 2:40 P.M., the Laundry Supervisor was asked to open the door (the one she indicated she thought provided access to the emergency shut off valve to the dryer) in the laundry. The door was locked. She took out her key chain and tried to unlock</p>				<p>laundry staff, fire policies and procedures will be learned and practiced through regular drills. Completion Date 6-10-2011</p> <p>All laundry staff will be in-serviced and trained on fire safety in the laundry area. Each laundry staff member will be required to demonstrate the use of a fire extinguisher and verbalize the placement of the fire pull in the laundry area and the building's gas shut-off valve. Completion Date 6-10-2011</p> <p>Drills will be performed that include scenarios where the gas shut-off valve will need to be accessed and turned off. Completion Date 6-10-2011</p> <p>A key to the door that leads to the back of the dryer will be placed on a hook outside the dryer enclosure. Laundry staff will be trained on when they would need to access the gas shut-off behind the dryers versus the main building's gas shut-off. Completion Date 6-10-2011</p> <p>ED/ Designee will randomly ask 20 employees a week on various shifts for 4 weeks to demonstrate where to shut off gas to the building in case of a fire. ED/ designee will then randomly ask 10 employees a week on various shifts for 4 weeks to demonstrate where to shut off gas to the building in case of a fire. Results will be forwarded to the QA</p>		

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	<p>the door. She indicated she did not have the key to unlock the door. She indicated she would page the maintenance man to come and unlock the door. At 2:41 P.M., she got on the phone and asked another staff member to page (maintenance Supervisor name). At this time, she indicated she was not sure of the location of the emergency fire pull for the department. She indicated she "had never been asked that before." She indicated she supervised 10 staff members.</p> <p>At 2:47 P.M., she got on the phone again and had the maintenance Supervisor paged again by a staff member. She indicated from that phone, they did not have the capability to page the maintenance Supervisor directly overhead, but needed to call another department to page the maintenance man. She indicated she could call the maintenance office but if no one was there, she would have to call another department and have them page the maintenance Supervisor for her.</p> <p>At 2:50 P.M., the Maintenance Supervisor arrived to the department. He indicated the 2 dryers were gas dryers. He stated that he and the assistant maintenance man were the only ones with keys to the door with access to the emergency gas shut off valve. He indicated the door enclosing</p>				<p>committee monthly x 2 months for review and further suggestions. Completion Date 6-10-2011</p>		

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	<p>the gas shut off valve had been in place for 1 year.</p> <p>On 5/12/11 at 4:15 P.M., the Administrator was interviewed. She indicated the maintenance Supervisor told the staff where the emergency shut off valve was during orientation.</p> <p>On 5/12/11 at 4:30 P.M., the Administrator provided a copy of a form titled "Environmental Tour." She indicated this was the information the maintenance Supervisor provided to new employees during orientation. The "tour" included, but was not limited to, the following: "Electrical and Gas shut offs". The Administrator indicated at that time, the main shut off valve to the gas dryers was outside by the generator. In the event of a fire, staff would turn the gas off by the outside access. The Administrator also indicated, at that time, a key had been placed in the laundry room to give staff access to the locked gas shut off valve located in the laundry department.</p> <p>On 5/16/11 at 8:30 A.M., the Administrator was interviewed. She indicated Laundry Staff #1 was the most recently hired staff in the Laundry department.</p> <p>On 5/16/11 at 8:30 A.M., Laundry Staff</p>						

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	<p>#2 was interviewed. She indicated she had been hired to the department in 2004. She indicated, in the event of a fire, she would take the key, which is now hanging by the door (to gain access to the gas shut off valve located behind the dryers). She indicated to turn off the gas shut off valve behind the dryers, she would pull up on the knob, located behind the door/dryers. Laundry Staff #2 indicated this was the only place she was aware of to turn off the gas shut off valve, behind the dryers. She indicated if there was a fire in her department, she would go up to the front of the building to let them know of a fire. She was unable to find a fire pull alert station in the laundry department. She indicated there was one fire extinguisher in the department. She indicated she was trained several years ago on how to use the fire extinguisher. Laundry Staff #2 indicated "when they do the training, I'm already gone for the day." She indicated she leaves for the day at 1 - 1:30 P.M.</p> <p>On 5/16/11 at 8:45 A.M., the Maintenance Supervisor was interviewed. He indicated if there was a fire in the laundry, he instructed/expected the staff to come to the main gas shut off valve, located out the back door from the laundry and around the corner of the building. He indicated there was no written policy and procedures for fire specific to the laundry</p>						

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	<p>department. He indicated the shut off valve turned gas off for the entire building. The valve was labeled, "gas shut off valve." The Maintenance Supervisor indicated that if there was a fire, even in the washer area/clean part of the laundry department, he would expect staff to come outside and turn off the gas shut off valve. He indicated inservices were done yearly regarding fire policy and procedures for all staff.</p> <p>On 5/16/11 at 8:50 A.M., the Maintenance Supervisor (MS) provided a copy of the material he reviewed at the staff annual inservicing. The MS indicated the annual inservicing was done around the middle of the year and was mandatory for all employees. At that time, the MS provided a copy of the information he shared at the annual staff inservicing. This included, but was not limited to, the following: "Fire Safety Pre/Post test; Fire safety - When the fire alarm sounds, and Fire Safety - Fire Drill Procedures."</p> <p>The Administrator provided a Census sheet, on 5/9/11 at 11:00 a.m., indicating there were 40 residents on Assisted Living Units.</p>						

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R0191	<p>(o) Each facility shall have an adequate kitchen that complies with 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to ensure sanitation solution was at adequate levels; kitchen dishwasher temperatures were consistently maintained at adequate levels; foods were stored covered, dated and labeled and/or disposed of according to facility procedure; serve pasteurized eggs when not thoroughly cooked; monitor refrigerator/freezer temperatures; maintain the kitchen in a sanitary manner; and/or ensure all staff (including non-dietary staff) were wearing hair restraints when in the kitchen, for 2 of 2 food preparation/serving areas and/or dining areas. (Main Dining Room, Main Kitchen)</p> <p>This deficient practice had the potential to affect 40 residents in the Assisted Living area.</p> <p>Findings include:</p> <p>1. Initial tour of the kitchen began on 5/9/11 at 9:20 A.M. Cook #1 was observed to take a cloth from the bucket on the counter and wipe off the food prep table. Cook #1 took the container of test strip paper, labeled "Phydration" and stuck the orange colored paper in the</p>			R0191	<p>R 191</p> <p>No residents suffered any ill effects from the deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice and through the in-servicing of staff and alterations of processes will ensure proper sanitation and food storage guidelines are being met. Completion Date 6-10-2011</p> <p>All dietary staff have been in-serviced on the proper way to check sanitizer levels in their cleaning buckets as well as the 3 compartment sink. Completion Date 6-10-2011</p> <p>FSM/Designee will monitor sanitizing solution stock weekly x 12 weeks. FSM/ Designee will also monitor sanitation cleaning buckets as well as the sanitizer in the 3 compartment sink 2 times a day for 2 weeks and then 1 time a day for 2 weeks. Random checking of sanitizing levels will be done by FSM/Designee for another 5 months. Results will be brought to QA monthly for review and recommendations if needed. Completion Date 6-10-2011</p>		06/10/2011

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	<p>bucket of solution being used. The paper was held in the solution under 5 seconds. When the test strip was removed, the color remained the same orange color as prior to the strip being placed in the solution. The result was read by Cook #1 as 100 PPM (parts per million). He indicated this bucket of solution had been poured 2 1/2 hours ago and the level of sanitation solution should be between 100 and 200 PPM.</p> <p>On 5/11/11 at 9:25 A.M., Dishwasher #1 was interviewed regarding the 3 compartment sink. He indicated the first sink contained soapy water for soaking items, the second sink was the rinse sink and the third sink is where staff filled their buckets with the sanitizing solution. The first sink was observed to have soapy water in it with various cooking pans in it, sticking up out of the water. The second sink was also filled with clear water as well as the third sink, also filled with clear liquid. Dishwasher #1 explained how the sanitizer is dispensed by a hose on the wall connected to a bottle of sanitizer. Viewing the bottle of sanitizer was obstructed as there were dish racks stacked up in front of it. Upon request, Dishwasher #1 was asked to test the strength of the sanitizer level in the 3rd sink. He took the test strips, labeled Phydration, and took the orange strip of</p>				<p>The dishwasher has been checked by the appropriate vendor to ensure the proper temperature can be maintained for sanitation of our dishes. Completion Date 6-10-2011</p> <p>All dietary staff have been in-serviced on the proper wash and rinse temperatures for the dish machine and who to call for assistance if temperatures are too low. Completion Date 6-10-2011</p> <p>The yellow pudding like substance that was unlabeled was thrown away. The roast type ham in the refrigerator that was dated 5-5-2011 was also thrown away. The roast beef that was partially opened and unlabeled was thrown away. The turkey that was opened and undated was thrown away. The bologna that was in the resealable package and had the date that had been torn through was thrown away. The vegetable soup that had no label was also thrown away. The reddish pool of liquid under the meat tray on the floor was cleaned and sanitized appropriately.</p> <p>The bag of frozen unlabeled fish was thrown out of the freezer. The speed racks in the refrigerator that were moved to get to the freezer had jello that spilled on the floor of the walk in refrigerator as they were moved. It was immediately cleaned up.</p>		

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	<p>paper and stuck it in the 3 compartment sink. He indicated he was to hold the strip in the water for 10 seconds. When he removed the test strip, it was the same orange color as when he removed it from the dispenser. Dishwasher #1 indicated they "were low on sanitizer." When the dispensing tube was followed along the wall, behind the stacked dish racks, an empty metal holder was observed. He indicated someone had "gone to get more" sanitizing solution.</p> <p>On 5/12/11 at 3 P.M., a copy of the May 2011 "Dishwasher Temp (temperature log) was received from the Administrator. This form had dishwasher temperatures documented for each of the 3 meals a day to date. Of the 36 rinse temperatures logged, 8 were documented to be below 180 degrees Fahrenheit. The low temperatures ranged from 170 - 179 degrees Fahrenheit.</p> <p>On 5/16/11 at 12 P.M., the Regional Representative [RR] was interviewed. He indicated the rinse temperature of the dishwasher should be at least 180 degrees Fahrenheit. He indicated that kitchen staff "have not been educated enough to be aware of required temperatures."</p> <p>2. During initial tour of the kitchen, on 5/9/11 at 9:30 A.M., Cook #2 entered the</p>				<p>The bowl of shrimp that was undated and unlabeled was thrown out.</p> <p>Plastic wrap was ordered and quantity and availability will be maintained by the FSM/ Designee. Food on the speed racks will be covered with plastic wrap. Completion Date 6-10-2011</p> <p>All dietary staff will be in-serviced on proper food storage procedures of food in the refrigerators as well as the freezers. The dietary staff will also be in-serviced on proper handling and usage of leftover foods. Completion Date 6-10-2011</p> <p>FSM/ designee will monitor the refrigerators and freezers daily x 6 months to ensure proper storage of food and leftovers is being done. The results of this monitoring will be forwarded to the QA committee for further recommendations if needed. Completion Date 6-10-2011</p> <p>All unpasteurized were thrown out. Staff was in-serviced on the policy of serving unpasteurized eggs. Completion Date 6-10-2011</p> <p>FSM/Designee will continue to monitor food orders to ensure the availability of pasteurized eggs to cook. Completion Date 6-10-2011</p> <p>Thermometers have been placed in all refrigerators and freezers per policy. All dietary staff including</p>		

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	<p>walk in refrigerator. He lifted a single serving bowl of a yellow pudding like food from the shelf. This bowl was not labeled. Cook #2 was unable to identify what was in the bowl. A roast type ham was observed on one of the shelves. Cook #2 indicated the date on the ham (which he identified to be approximately 3 pounds) had a date of 5/5/11. Cook #2 indicated this ham should have been thrown out on 5/8/11, as they keep potentially hazardous foods for only 3 days. A package of roast beef, identified by Cook #2 to be approximately 3-4 pounds, was partially covered with plastic wrap. Cook #2 indicated this roast beef was lacking a date. A package of turkey meat (2 ounces) was opened but not dated as to when it was opened. An opened package of bologna was also observed. This was in a resealable package but was not dated as to when it was opened and the use by date on the package was unable to be read as it had been torn through. A sheet pan was observed in the walk in refrigerator with an uncut baked cake in it. The cake was not covered or dated. A 15 quart container was observed with vegetable soup in it. This container was undated. Cook #1 indicated the soup had been made yesterday. A pool of a reddish liquid type substance was observed around the base of a leg of one of the shelves in the walk in refrigerator. The</p>				<p>our regional representative have been in-serviced on where the thermometers are located as well as safe temperature ranges for the freezer and refrigerators. Each dietary staff member has been in-serviced on where to record daily temps and who to contact if temperatures are not within range. The in-service included the disposal of food that ever encounters out of range temperatures. Completion Date 6-10-2011</p> <p>All food in the stand up freezer was disposed of. A freezer log was placed on the outside of the stand up freezer. Maintenance was called to check the temperature problem in the freezer. The freezer was fixed. Completion Date 6-10-2011</p> <p>All equipment has been pulled out and the floors have been cleaned including the edges. Completion Date 6-10-2011</p> <p>The hand washing sink has been thoroughly cleaned and the trash can removed with a new one placed by the hand washing sink. All spatters on the walls have been wiped clean. All shelves have been cleaned as well as a new microwave purchased and the old stained one thrown out. Completion Date 6-10-2011</p> <p>The staff have been in-serviced on the proper way to keep trash contained and the trash overflowing</p>		

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	<p>diameter of the pooled reddish liquid was at least 5 inches and was drying on the edges. Directly above the reddish pool, was a case of beef, placed directly on the metal shelving.</p> <p>At 9:45 A.M., the walk in freezer was observed. A bag of frozen, unbreaded fillet type fish was observed. The fish was in a bag, which Cook #2 identified as not having a date, and observed that the bag was not sealed, but had a hole, at least 6 inches in diameter in the exposed side of the bag. The bag was not labeled as to its contents.</p> <p>At 1:30 P.M., Cook #2 indicated he was going to dispose of the fish fillets in the walk in freezer in the opened bag. Cook #2 was in the walk in refrigerator and moved a standing, wheeled rack with large uncovered, pans of red liquid in them. When Cook #2 moved the rack, the wheel stuck and the pans of red liquid spilled and splattered on the floor of the walk in refrigerator.</p> <p>A covered bowl of cooked shrimp was observed at 2 P.M. on the bottom shelf of the walk in refrigerator. This shrimp was not dated. The bowl had water in it and that pan was placed in a pan with ice in it. The temperature of the shrimp was 30 degrees. Cook #1 indicated the pre</p>				<p>in the trash can was taken out. Completion Date 6-10-2011</p> <p>The staff have been in-serviced on how to properly wash the floor mats in the dish room. They have also been in serviced on proper use of the three compartment sink and cross contamination. Completion Date 6-10-2011</p> <p>All staff will be in-serviced on the washing of the hand sink as well as the 3 compartment sink. Completion Date 6-10-2011</p> <p>Cleaning schedules have been posted and staff has been in serviced on their individual responsibilities for kitchen sanitation. Completion Date 6-10-2011</p> <p>FSM/designee will monitor the cleaning schedules daily x 6 months to ensure staff is performing assigned duties. Audits will be forwarded to the QA committee for further review and recommendation as needed. Completion Date 6-10-2011</p> <p>Staff has been in serviced on the use of hair restraints in all kitchen food prep areas. Hair restraints have been placed outside the dining room so staff other than dietary that need to enter the kitchen may do so with a hair net in place. Completion Date 6-10-2011</p> <p>Overall sanitation will be monitored by the FSM/Designee on a weekly</p>		

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	<p>cooked shrimp had been thawed in the refrigerator in the package yesterday and when they were thawed, water was added.</p> <p>On 5/10/11 at 8:20 A.M., the reddish liquid observed pooled at the base of the shelf leg in the walk in refrigerator was again observed. The reddish puddle was approximately 6 inches in diameter.</p> <p>At 8:20 A.M. on 5/10/11, Cook #3 was interviewed regarding ham in the walk in refrigerator. She indicated the chunk of ham was about 3 pounds. The cut ham was covered with plastic wrap but was not dated. She indicated the ham had been opened yesterday. She removed the ham from the refrigerator and placed it in a plastic container and dated it.</p> <p>At 9 A.M., Cook #3 toured the walk in freezer. The opened bag of frozen fillet type fish remained in the walk in freezer. Cook #3 threw the opened bag of frozen fish away.</p> <p>On 5/11/11 at 8:30 A.M., the walk in refrigerator was observed. The reddish puddle remained around the same leg of shelving as observed on 5/9/11 and 5/10/11.</p> <p>On 5/11/11 at 11:45 A.M., the RR provided a copy of the undated policy and</p>				<p>basis through a sanitation score card checklist. Sanitation checks will be completed weekly for 6 weeks and then months thereafter for 10 months with the results being forwarded to the QA committee for further review and recommendations as needed.</p> <p>Completion Date 6-10-2011</p>		

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	<p>procedure for "Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance." The procedure, included but was not limited to, the following: "Food is covered, dated and stored loosely to permit air circulation...Prepared perishables such as...puddings...are stored in a refrigerator and covered, labeled and dated until used...left overs are refrigerated immediately and used within 72 hours or frozen...All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers to prevent freezer burn. Items are labeled and dated.</p> <p>On 5/11/11 at 3:08 P.M., the kitchen was toured with the RR. At this time, Cook #2 was asked by the RR to cover the pans of carrot salad which were observed in the walk in refrigerator on standing racks uncovered. Cook #2 indicated they didn't have any plastic wrap. The carrot salad was then covered with cookie sheet type pans.</p> <p>On 5/12/11 at 11 A.M., the RR was interviewed. He indicated "we have really fallen short on giving them (staff) the tools they need to succeed." He indicated inservicing had begun on that date.</p> <p>On 5/12/11 at 11:30 A.M., the RR</p>						

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	<p>provided a copy of the policy and procedure for "Leftover foods will be utilized in an appropriate and safe manner to aid in controlling waste." This policy was undated. The procedure included, but was not limited to, the following: "...Leftovers should be covered, dated, labeled...as soon as meal service is finished...leftovers which are frozen are covered so they are air-tight and moisture proof. They are labeled with item and date...The Dining Service Manager or cook checks for leftovers each morning and determines how to use them..."</p> <p>3. During initial tour of the kitchen on 5/9/11 at 9:30 A.M., the walk in refrigerator was observed. Five boxes of 18 count eggs were observed. Cook #2 indicated these eggs had just been bought from a local grocery, as they had run out of eggs and the eggs were not pasteurized. He indicated they were getting a food order in on that day.</p> <p>On 5/11/11 at 8:40 A.M., Cook #1 was observed in the kitchen. A container housing shelled eggs was observed on the counter. No markings were observed on these eggs. At this time, Cook #1 took two of the shelled eggs from the counter, cracked them and put them in a hot skillet. He then put them on a plate with additional breakfast food and started to</p>						

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	<p>walk out of the kitchen. At that time he was interviewed. He indicated the eggs he just cooked were not pasteurized and were cooked with the whites to a medium. He stated the yolks were not hard cooked. Cook #1 indicated that sometimes they run out of eggs and buy them. He indicated he thought if the whites were cooked over medium it was OK to serve them. At this time Cook #3 was interviewed. She indicated she thought unpasteurized eggs had to be cooked hard. Cook #1 then threw the medium cooked eggs out.</p> <p>On 5/11/11 at 2 P.M., the RR provided a copy of the Policy and procedure for "safe and sanitary handling of food will be employed during food production." This policy was undated. This policy included, but was not limited to, the following: "only pasteurized raw eggs are served."</p> <p>On 5/12/11 at 11:A.M., the RR was interviewed. He indicated that all eggs should be pasteurized. He indicated they were in a "situation where they ran to store and bought other (non pasteurized) eggs."</p> <p>4. During initial tour of the kitchen on 5/9/11 at 9:45 A.M., the walk in freezer was observed. Cook #2 was looking for the thermometer to read the current</p>						

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	<p>temperature. Cook #2 was unable to find a thermometer in the walk in freezer.</p> <p>A form titled "Refrigerator/Freezer Temp Log" was observed on the outside of the walk in refrigerator/freezer door. This log had no date for the "Month" on the form but was completed through the ninth of the month. The temperature for each entry for the walk in freezer was "-11."</p> <p>At 9:50 A.M., the milk cooler was observed. Cook #1 was unable to locate a thermometer to check the current temperature in the cooler.</p> <p>At this time, the temperature to the stand up freezer was read by Cook #2 as 31 degrees (Fahrenheit). There were 5 large, 3 gallon drums of ice cream. One of the containers had a paper lid, which was not sealing the ice cream closed. Three fourths of the paper lid round was separated from the edge, thus exposing ice cream. The container had approximate 1/3 of the ice cream missing. The ice cream was observed to be melting, with soft mushy ice cream observed from the inside edge of the container, at least 1 inch in toward the center of the container. Fluid ice cream was observed in the center of the ice cream. Cook #2 threw this drum of ice cream away. All 5 drums of ice cream were soft enough to be able to be</p>						

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	<p>pushed in when touched from the outside of the container. One of the other unopened containers of ice cream was opened with the same degree of melting observed as above, with mushy ice cream observed at least 1 inch in from the inside edge of the container. Cook #2 indicated "this shouldn't be" and thought maybe the freezer was in defrost mode. He notified the maintenance man of the freezer. While waiting for the maintenance man, Cook #2 began emptying the stand up freezer. He removed the following: 4 remaining drums of ice cream; a case of 48 count "magic cup" food items, with approximately 10 magic cups missing (when pushed on one of the lids of the magic cup, the melted substance emerged from the edges of the lid); 3 pre packaged cream pies; 2 cases of 50 count, 4 ounce servings, of mighty shakes and one 75 count case of 4 ounce mighty shakes was also removed from the freezer. These cartons were able to be pushed on the sides when felt. Cook #2 indicated the food items shouldn't be soft. A single carton of mighty shake was removed from the back of the freezer and was frozen solid when the carton was touched. At 10:05 A.M., the above items were moved to the walk in freezer on a cart. Also removed from the freezer were 3 boxes of 40 count cookies; one prepackaged cheesecake, chocolate layer cake</p>						

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	<p>(prepackaged); and 4 prepackage loaf pound cakes. An angel food cake was observed to have one, one inch slice missing. This angel food cake was not completely covered, was not dated and was also observed to be soft.</p> <p>On 5/9/11 at 11 A.M., a copy of the "Refrigerator Temp (temperature) log was received from the a This is the log which hung in the kitchen on the refrigerator/freezer. This log was completed for The "month" area was left blank. The categories form included the following: "walk in refrigerator freezer; reach in refrigerator; milk cooler." Doc was lacking on this form of an area to document freezer temperatures.</p> <p>On 5/9/11 at 1:32 P.M., the temperature of the stand up freezer was observed to be 8 degrees F. The freezer was empty at the time.</p> <p>On 5/11/11 at 11:45 A.M. a copy of the policy and procedure for "Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance." This policy was undated. The procedure included, but was not limited to, the following: "Thermometers are placed in every refrigeration unit so as to be easily visible for checking and in the upper third part of the front of the storage unit. Temperatures will be recorded on the</p>						

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	<p>Refrigerator log at least twice a day...Frozen storage temperatures will be at 0 degrees F (Fahrenheit) or below...Temperatures will be recorded on the Freezer Temperature log at least twice a day."</p> <p>Documentation was lacking of the reach in freezer temperature being monitored at all and/or any refrigerator and/or freezer having had temperatures monitored twice a day.</p> <p>On 5/11/11 at 2:50 P.M. a tour was conducted with the Facilities Regional Representative (Rep.) (RR). In the main dining room, located directly off the kitchen, the RR was unable to locate log, documenting the temperature was being monitored in this refrigerator.</p> <p>At 3:08 P.M., the walk in freezer was toured with the RR. He was unable to find a thermometer.</p> <p>At 3:13 P.M., the milk cooler was toured with the RR. He was unable to find a thermometer in the milk cooler.</p> <p>On 5/16/11 at 2 P.M., the Administrator indicated on the evening of 5/8/11, the Dietary staff left the department about 10 P.M. She indicated when the dietary staff arrived the morning of 5/9/11, the</p>						

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	<p>temperature in the reach in freezer was 60 degrees Fahrenheit. She indicated she was informed that the door to the reach in freezer had not closed properly the evening of 5/8/11, the fan froze up to the reach in freezer, thus leading to the increased temperature.</p> <p>5. During initial tour of the kitchen, on 5/9/11 at 9:20 A.M., the following was observed:</p> <p>The flooring of the kitchen was observed to have scattered dust, debris and bits of food items, especially along the wall edges and around the legs of tables and appliances.</p> <p>The only hand wash sink was observed with the following: in the base of the sink was a small brush and a sponge with seeds on it. The basin of the sink was observed to have brownish areas of residue scattered throughout. The same brownish residue was observed along the top edges of the faucet fixture and along the edges of the sink. The wall behind the sink was observed to have various splatters throughout up to chest level on the wall. The hand wash sink was located next to a covered, foot pedal operated trash can. The lid to this trash can was heavily laden with various splatters of dried substances. The trash can was</p>						

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	<p>sitting in a corner. The walls on the back and side of the trash can were also laden with splatters of dried substances, from chest height on the wall down.</p> <p>The open shelf underneath the sink in the cooking area was observed. This shelf had at least 2 buckets of sanitizer solution on it. Throughout the shelf were areas of dark black brown sticky residue .</p> <p>The microwave was observed to have dried spatters of a light substance on the outside of the oven. When opened, the based of the microwave was observed to have a very dark, blackish colored substance. This substance covered the front half of the oven bottom, extending back from the edge at least 2 inches. Dried splatters were also observed throughout the microwave. This black substance was able to be scraped off.</p> <p>The large wheeled trash can was observed, at 1:10 P.M. in the cooking area and the dishwashing area, to be overflowing and without a lid.</p> <p>On 5/10/11 at 8:20 A.M., the hand wash sink was observed again. The small brush remained in the sink basin as observed on 5/9/11. The condition of the sink, walls and covered trash can also remained the same as observed on 5/9/11.</p>						

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	<p>On 5/10/11 at 8:20 A.M., the floor condition, shelf condition and the microwave remained the same as observed on 5/9/11.</p> <p>On 5/11/11 at 9 A.M., the microwave was again observed. The dried spatters to the outside and the dark substance to the inside remained as observed on 5/9/11 on initial tour.</p> <p>On 5/11/11 at 9:10 A.M., the hand wash sink was again observed. The small brush remained in the sink basin as observed initially on 5/9/11. The condition of the sink, walls and covered trash can also remained the same as observed on 5/9/11.</p> <p>On 5/11/11 at 9:10 A.M., the open shelf under the sink in the food prep area remained the same as observed on 5/9/11 at 9:20 A.M.</p> <p>On 5/11/11 at 11:15 A.M., Dishwasher #2 was observed in the dish room. Dishwasher #2 picked up a rubber mat from the floor and placed it on the dirty dish work space. The rubber floor mat was laying flat and he then took the dish water nozzle with a brush on the end of it and began scrubbing the rubber floor mat. This is the same dish water nozzle observed to cleanse dirty dishes prior to</p>						

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	<p>being run through the dishwasher. He then rolled the rubber floor mat up and placed it in the second compartment of the three compartment sink, where there was another black rubber floor mat rolled up. He then began scrubbing the dish area floor and walls with a brush/broom.</p> <p>At 11:40 A.M. on 5/11/11, Dishwasher #2 began running water into the second compartment of the 3 compartment sinks. The rubber mats had been replaced to the floor. Dishwasher #1 was interviewed. He indicated they clean the sink twice a shift and it was cleaned right after breakfast. He indicated he had not cleaned the 3 compartment since after breakfast.</p> <p>At 12:15 P.M. on 5/11/11, a pan was observed soaking in the 2nd compartment of the 3 compartment sink.</p> <p>At 12:15 P.M., Dishwasher #1 was interviewed. He indicated they were out of sanitizer solution. He indicated they had some for breakfast but were out at that time.</p> <p>At 12:20 P.M., the RR returned with sanitizer solution and indicated, "this will be hooked up right now."</p> <p>At 12:20 P.M. Dishwasher #2 was</p>						

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NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>interviewed. He indicated he had not washed any of the 3 compartment sinks today.</p> <p>On 5/11/11 at 4:55 P.M., the RR was interviewed. The RR indicated the FSM and the AFSM monitored kitchen sanitation and he monitored them.</p> <p>On 5/12/11 at 9:45 A.M., the kitchen was toured with the RR. The condition of the sink remained as observed on 5/9/11, 5/10/11 and 5/11/11. The RR indicated the brush, lying in the base of the sink, was probably used to clean employees' fingernails with.</p> <p>On 5/12/11 at 11:30 A.M., the RR was interviewed. He indicated he was unable to locate any completed documented cleaning schedules for the kitchen. He indicated the last completed cleaning schedule was done before the FSM left.</p> <p>On 5/12/11 at 11:45 A.M., the Policy for "The handwashing sink will be cleaned and sanitized on a routine basis according to defined procedures" was reviewed. This policy was dated 2009 and was received from the RR at the time of review. Documentation was lacking as to the specification of "routine basis" regarding frequency of cleaning.</p>						

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	<p>On 5/12/11 at 12:20 P.M., blank copies of the daily, weekly and monthly cleaning schedules were received. Daily Tasks included, but were not limited to, the following: "3 well sink, each use; hand sink; juice machine each meal; microwave; floors sweep/mop; work table cooks area; work tables serving area."</p> <p>6. On initial tour of the kitchen, on 5/9/11 at 9:20 A.M., the kitchen was observed in the following manner: The one main entry door to the kitchen was from the main dining room. The one main walk way from the front of the kitchen to the back, went directly by the food prep table area. The food prep/cook area was located directly in the kitchen off to the left of the main walk way. Staff were observed, at the time, to walk into the kitchen without hair restraint on and place "meal tickets" (with residents' food orders on them) on the side of the ice machine. The ice machine was also located across a walkway from the shorter side of the food prep table.</p> <p>On 5/9/11 at 10:15 A.M., the Administrator was observed walking into the kitchen without a hair restraint in place. At the time she walked by the food prep table, uncovered chicken breasts were on the counter being prepared.</p>						

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	<p>On 5/9/11 at 12 P.M., Physical Therapy staff #1 was observed inside the kitchen door without a hair restraint on. Meal preparation was in progress at the time.</p> <p>On 5/11/11 at 8:15 A.M., the SSD (social service director) entered the kitchen without hair restraint on. She walked in the front door of the kitchen, through the main walk way, by the food prep area and walked to the back of the kitchen.</p> <p>On 5/11/11 at 8:20 A.M., LPN #1 entered the kitchen without a hair restraint on. He took a meal order ticket, entered the kitchen went over to the ice machine stating "order in" and stuck the order ticket on the side of the ice.</p> <p>On 5/11/11 at 9 A.M., the Maintenance Supervisor, accompanied by an outside service worker walked through the main walk of the kitchen. The service worker did not have any hair restraint on. The Maintenance Supervisor was observed with a ball type cap on.</p> <p>On 5/12/11 at 11:30 A.M., the RR was interviewed. He indicated anyone going through the kitchen area should have a hair restraint on. He also indicated the food prep area was along the only path through the kitchen from front to back.</p>						

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	<p>On 5/12/11 at 11:45 A.M., the undated policy and procedure for "Nutrition Services Department employees will dress appropriately and practice good hygiene" was received from the RR. The policy included, but was not limited to, the following: "The organization has strict requirements regarding hair: Employees will wear hairnets that COMPLETELY covers the hair while in the kitchen or serving food."</p> <p>The Census Sheet, provided by the Administrator on 5/9/11 at 11:00 a.m., indicated there were 40 residents residing on the Assisted Living Units in the facility [Residential level of care].</p>						